Oregon
John A. Kitzhaber, MD, Governor

Department of Human Services
Aging and People with Disabilities
State Unit on Aging
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DHS
Oregon Department of Human Services

December 28, 2012

Scott Bond
Oregon Cascades West Council of Governments
1400 Queen Avenue SE
Albany, OR 97321

Dear Scott:

I am pleased to inform you that the Oregon Cascades West Council of Governments' Area Plan on Aging for 2013 – 2016 has been approved for the period January 1, 2013 through December 31, 2016.

The State Unit on Aging staff looks forward to working with you in the implementation of the Area Plan. If you have questions or concerns, please do not hesitate to contact us.

I appreciate your dedication and commitment toward improving the lives of older Oregonians. Sean Scott will continue as the SUA staff liaison to your agency.

Sincerely,

Elaine Young

Elaine Young
Manager, State Unit on Aging

Cc: Sean Scott, SUA

Oregon Cascades West Council of Governments

DISTRICT 4 SERVING LINN, BENTON AND LINCOLN COUNTIES

OLDER AMERICANS ACT

AREA PLAN

For Period of

JANUARY 1, 2013

to

DECEMBER 31, 2016

Area Agency on Aging and Disability Services

Linn, Benton, & Lincoln Counties

Cynthia Solie	Scott Bond
OCWCOG Executive Director	SDS Director

Special Acknowledgements

Advisory Councils

Senior Services Advisory Council

Disability Services Advisory Council

Prepared by:

Ronnie Louise Hansen, MSW, Project Specialist

OCWCOG Senior & Disability Services

2013-2016 Area Plan

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Section A: Area Agency Planning and Priorities

A-1 Introduction

Oregon Cascades West Council of Governments (OCWCOG) Senior and Disability Services (SDS) is the designated Area Agency on Aging (AAA) and the designated Type B Transfer organization for the Department of Human Services (DHS) managing the Medicaid Long Term Services and Supports, Supplemental Nutrition Assistance Program (SNAP) and Oregon Health Plan (OHP) programs for Linn, Benton and Lincoln Counties. The agency also manages the Benton County Veteran's Services contract on behalf of the county.

The OCWCOG is a voluntary association of twenty cities, three counties, the Confederated Tribes of the Siletz Indians and a port district.

Geographically, the OCWCOG spans a region from the crest of the Cascade Range to the Pacific Ocean and includes all of Linn, Benton and Lincoln Counties. The OCWCOG provides member governments and the people living within the region a broad range of programs and services.

SDS provides a wide range of services through the Older Americans Act (OAA) funds, Oregon Project Independence (OPI) funds, Medicaid Program Administration funds and a variety of services operated or enhanced through grants and fundraising activities. All of our services and programs are focused on serving the region's older adult population as well as those with long term physical disabilities and veterans.

The region of Linn, Benton and Lincoln Counties has two population centers of over 50,000 residents and unincorporated areas in the counties that are rural and require most residents to travel to obtain the majority of their services such as health care, retail services and access to leisure and recreation. Our program focuses on providing access to services for older adults and people with physical disabilities who are at risk, socially, financially or medically, living in rural settings.

Within our region we maintain healthy partnerships with the County Health Departments. As partners, we work together on the promotion of Chronic Disease Self Management Programs (CDSMP) across the region, make referrals to Federally Qualified Health Centers (FQHC), which serve low income and indigent residents, and participate in grant writing for the planning and delivery of new services. We also work with the Linn and Benton County Health Department staff on supporting the Healthy Aging Coalition of Linn and Benton Counties. As co-

founders and supporters of the coalition, we are working to highlight issues, conduct public education and awareness events and work with the professional community to improve services within the two counties.

OCWCOG is also involved with the Long Term Services and Supports (LTSS) provider community. We work with licensed facilities, community based agencies providing supportive services and the in-home provider network to assist in delivering the highest quality services to our citizens.

Over the last two years, we have established new services and relationships with the medical community delivering new programs and preparing for the region's new Coordinated Care Organization (CCO), which will serve our three counties. Our partnership not only includes the Intercommunity Health Network (IHN)/Samaritan Health Services (SHS), but also the counties and the managed behavioral health organizations in the region as we develop plans to better serve the Medicaid eligible population through the new CCO. A significant proportion of the CCO eligible populations are associated with our programs. Planning and coordination opportunities are critical for us to develop a CCO system of care that provides access to care, better care and is budget neutral overall.

The purpose of an AAA, as created through the OAA, is to administer and plan service programs that help older adults maintain their health and independence in their homes and communities. AAA's also advocate for all older adults in the region, identify the needs of older adults and develop a multi-year plan to develop comprehensive community based services to meet such needs and administer federal OAA funds. AAA's contract for, or provides services directly, monitor and evaluate services and contracts, coordinate services and do their best to ensure that needed services are developed in the community. Funding limitations and the lack of the State of Oregon participating in the funding of OAA programs with State general funds, creates significant barriers to this mission along with stagnant funding at the federal level through OAA. Many other states contribute significantly to the federal funds to expand and enhance the quantity and diversity of programs available for older adults.

SDS has three offices within Linn, Benton and Lincoln Counties. All offices provide full access for persons with disabilities.

Albany Senior and Disability Services

1400 Queen Avenue S.E., Suite 206

Albany, OR 97322

(541) 967-8630 Voice & ADRC

(800) 638-0510 Toll free

(541) 924-8402 TTY

(541) 812-2581 Fax

Corvallis Senior and Disability Services and Veterans Services

301 SW 4th

Corvallis, Oregon 97333

(541) 758-1595 Voice

(800) 508-1698 Toll free

(541) 758-3126 TTY

Toledo Senior and Disability Services

203 N. Main St.

Toledo, OR 97391

(541) 336-2289 Voice & ADRC

(800) 282-6194 Toll free

(541) 336-8103 TTY

(541) 336-1447 Fax

Our offices provide services based on income and resource criteria to adults aged 60 and older, and people with disabilities under the age of 65. The office structure

and procedures are consistent throughout the region. Residents can access all of our resources through the Aging and Disability Resource Connection (ADRC), which serves as the front door for all of the resources in the region.

In addition to the Senior and Disability Programs, the OCWCOG also serves the region by providing the following services:

Economic Development: OCWCOG provides federally and state funded region-wide economic strategy planning, staffing for grant and loan programs and project level technical assistance. OCWCOG also provides staffing for projects serving one or several local governments within the three counties. OCWCOG is the federally designated Economic Development District for Linn, Benton and Lincoln Counties as well as Lane County.

Transportation: OCWCOG staffs state and federally authorized region-wide and sub-regional transportation planning agencies including the three-county Cascades West Area Commission on Transportation and the Corvallis Area Metropolitan Planning Organization. The organization also manages the regional Medicaid Transportation Brokerage through a DHS contract providing non-emergent medical transportation for residents of the region.

Community Development: OCWCOG provides staffing to assist communities to plan for public improvements and implement those improvements. This service is available to all communities and member entities within the three-county area.

Technology Services: OCWCOG provides staffing to deliver comprehensive, agency-wide information technology management. Services include network implementation, software and web site development, computer and phone maintenance, consulting, and project management for OCWCOG departments and by contract to other agencies.

General OCWCOG Administration: OCWCOG Administration provides all human resources, financial and general agency management services with the exception of legal services.

Copies of the OCWCOG Area Plan in its entirety may be found at all City libraries throughout the three counties. Questions and comments on the plan may be addressed to Scott Bond, Director of Senior and Disability Services. Phone contact is 541-812-6008. E-mail contact is sbond@ocwcog.org.

A-2 Mission, Vision, Values

Senior and Disability Services (SDS) has a mission to provide leadership and services for seniors and people with disabilities to enhance their independence, dignity, choice, and individual well being.

SDS holds a vision of serving as the regional experts in aging and disability services and supporting the regional population to maintain health, wellness and access to programs when needed.

SDS work is defined by several key values that we have used to help us plan services. SDS is committed to providing high quality services and excellent customer care. We plan for the future with a proactive approach to developing new services that will meet the needs of the community as the demographics evolve and the technology of service delivery changes.

Our work with the State Unit on Aging (SUA) in Oregon has been based on a goal of developing a partnership to build a service system for the future. An example of this approach has been the work done to implement the Aging and Disability Resource Connection (ADRC). The partnership has resulted in the implementation of a fully functioning ADRC for our region with a very small investment from State and Federal funds. The Oregon approach has been to use federal grant funding to build the infrastructure such as public web sites, call center tools for staff to record data and a statewide toll free number. Federal grant support was used to develop areas such as Options Counseling training to jump start this work in the community.

With the development of Coordinated Care Organizations (CCO) across the state, our partnership with the Intercommunity Health Network (IHN) has become deeper and stronger. We are working together with IHN to develop and implement the long term services and supports system's role in the new CCO.

Our region participates in two formal consortium contracts where our partners are the surrounding Area Agencies on Aging (AAA), NorthWest Senior & Disability Services and Lane Council of Governments (LCOG) Senior & Disabled Services (S&DS). In the delivery of our Senior Nutrition Program, we work together in a partnership to negotiate and purchase meals served throughout eleven sites within our region. We also participate in a consortium agreement to purchase agency based in-home care for clients who need support not easily delivered by individual home care workers.

The Healthy Aging Coalition is now over two years old and continues to examine key community issues and talk about how to support local older adults. With a growing list of supporters, small grants, Oregon State University (OSU) students assisting with planning projects and ongoing planning discussions, we continue to work together on raising community awareness and educating professionals from different backgrounds about how we can come together to support older adults. A recent example of this is the connections being made to conduct outreach for the Supplemental Nutrition Assistance Program (SNAP) benefits underutilized by older adults. We are also forming connections between the Gleaners Program, Oregon Food Bank, local Farmers Markets, Senior Meals sites, Retired Senior Volunteer Program (RSVP) and the volunteer network that supports the meals program. We have learned much, and look forward to continuing this work.

We have worked hard to keep positive relationships with nursing facilities, assisted living programs and adult foster homes. These relationships not only assist case managers serving individuals utilizing Medicaid in such facilities, but also ensure that we are a partner in the long term services and supports system throughout this region. We help to develop new resources and specialized care settings for our clients. We also serve individuals who live at home or in another setting of their choice. Our provider organizations are a key part of these planning discussions.

Combating abuse and neglect is a major priority for our organization. SDS is an active member of local Multi-Disciplinary Teams (MDT) within all three counties and the Vulnerable Adult Support Team (VAST) in Linn and Benton Counties. These teams consist of local law enforcement, District Attorney representatives, county Mental Health programs, Legal Aid Services of Oregon and other community partners. These groups meet monthly to staff complex Adult Protective Service (APS) cases that challenge us to protect older adults and people with disabilities. These meetings also provide an opportunity for SDS to build stronger relationships with community partners.

Throughout all SDS processes, we embrace and value a diverse workforce and recognize the importance of full inclusion to all of our programs and services, regardless of race, ethnicity, gender or sexual orientation.

In all examples cited above, our staff are held to high standards and thoroughly trained to maintain professional, respectful and creative community relationships. During interactions with clients, families, partner organizations or another part of the agency, our staff is knowledgeable and ready to lend a hand. Our management team consists of experts who support the work of staff, as well as represent the agency in the community.

A-3 Planning and Review Process

The planning process used for the development of this Area Plan has been underway for several months. The needs assessment for this document is based on a combination of community outreach, input from Senior and Disability Services direct services staff, and management and statistical analysis of our region's older and disabled population.

We took three steps to achieve meaningful community input when evaluating need and developing goals and objectives for this Area Plan. Our first outreach was in the form of consumer, staff and community partner surveys. In all consumer survey distribution, individuals living in rural areas as well as ethnic and cultural minorities in the region were included. Our next step was community forums, one in each of the three counties we serve. Community members were invited to join OCWCOG at their local senior center for discussion of senior and disability related issue areas. All community forums were advertised on local radio stations, newspapers and community bulletin boards. The final step in our community input process included two focus groups where a diverse collection of senior and disability focused professionals from the community came together for in depth discussion of local need topics. Complete summaries of survey, community forum and focus group data are included in Appendix C.

In addition, we utilized a variety of data sources to provide us with information about our region and current services being delivered. The sources of data include: census data, Department of Human Services (DHS) service data, regional demographic reports, Oregon Cascades West Council of Government's (OCWCOG) 2012 Work Program and Budget and the American Community Survey. A complete list of resources can be found at the end of this document.

The OCWCOG Senior and Disability Services (SDS) Advisory Councils played an integral role in the development of this Area Plan. Advisory Council members helped plan, and participated in, community forums and focus groups. The Councils reviewed and voiced their perspectives concerning the general direction of the plan and specific issue during the council meetings. We also utilized both councils on multiple occasions during the editing and review process. The Senior Services Advisory Council, the Disability Services Advisory Council and the OCWCOG Board of Directors have adopted this Area Plan.

The writing of this area plan is a cooperative body of work developed by the SDS's management team. This team met regularly throughout the development process to discuss the direction and progress of the plan. Program managers, supervisors and direct service staff were consulted throughout the development and editing of

narrative, goals and objectives. The OCWCOG Executive Director, with a strong background in organizational planning, was also able to provide guidance throughout this process.

Included below is a list of community surveys, forums and focus groups that were conducted to support this planning process.

Surveys

- Family Caregiver Support Program Consumer Survey, 2010
    - This survey was conducted to understand the program participant's view of the services. We gathered information through multiple distribution sources including physical mail, telephone and in-person interviews. Ultimately, there was a 67% response rate. Detailed results of this survey are described in Section C: Issue Area 1: Family Caregivers.
- SDS Consumer Survey, 2011
    - This survey was sent via paper mail to individuals served within our three county area. The survey was sent to receive consumer feedback on the satisfaction rate and suggestions for improvements from the consumer perspective. The 904 completed surveys represented a 10% response rate.
- SDS Staff Survey, 2012
    - This survey was sent via Survey Monkey to all SDS staff members. The purpose of the survey was to solicit feedback from our staff related to the services we offer, improvements and new ideas for supporting our region. The 62 completed surveys represented a 65% response rate.
- Community Partner Survey, 2012
    - This survey was sent via Survey Monkey to a comprehensive list of community partners in our area. Our partner survey was sent to provide those organizations that we work with on a regular basis a chance to offer their perspective on what we were doing well and what could be improved upon. We also wanted to understand which programs were being used most often. The 20 completed surveys represented a 29% response rate.

SDS Community Forums

All of the community forums were developed to bring community members together to discuss community needs and gaps in services.

- Albany, 2012
    - 10 community members attended along with OCWCOG's Program Support Supervisor, Project Specialist and Program Manager.
- Corvallis, 2012
    - 11 community members attended along with OCWCOG's Program Support Supervisor, Project Specialist and Program Supervisor.
- Newport, 2012
    - 5 community members attended along with OCWCOG's Program Support Supervisor, Project Specialist and Program Manager.

Healthy Aging Coalition Community Forums

All of the community forums were developed to bring community members together to discuss community needs and gaps in services.

- Corvallis, 2012
    - 19 community members attended along with OCWCOG's SDS Director and Project Specialist.
- Albany, 2012
    - 13 community members attended along with OCWCOG's SDS Director and Project Specialist.

SDS Focus Groups

The focus groups were organized to solicit opinions from selected community partners. They were asked to help us by providing specific ideas and suggestions related to services for older adults and people with disabilities.

- Corvallis, 2012
    - 11 senior and disability focused professionals from the community attended along with OCWCOG's Program Support Supervisor, Project Specialist and Program Manager.
- Albany, 2012
    - 13 senior and disability focused professionals from the community attended along with OCWCOG's Program Support Supervisor, Project Specialist and Program Supervisor.

A-4 Prioritization of Discretionary Funding

A small amount of Senior and Disability Services' (SDS) budget is considered flexible spending or discretionary. It is our job to prioritize this money to best serve the unique needs of our region. Title III-B discretionary funds refer to money available after meeting the minimum Title III-B expenditure requirements. For the purpose of this document, discretionary funds also include local sources used to supplement the provision of services meeting the Older Americans Act (OAA) definition. SDS staff engages in fundraising and grant writing, along with collaborating in community partnerships, to maximize discretionary funds. With Federal, State and local budget reductions in recent years, older adults and others served by this Area Agency on Aging (AAA) have experienced program reductions as a result of the economic downturn. With this frayed service net in mind, we have outlined the following use of discretionary funds to best serve our clients. Throughout the allocation of these funds, situations of individuals with the greatest economic and social needs are always prioritized.

Prioritization of discretionary funding and fundraising is based on input from our staff, Advisory Councils and consumers in our region. Current priorities include:

- Meals on Wheels (MOW)
- Family Caregiver Support Program (FCSP): respite, supplemental services, and training for caregivers
- Expansion of the Money Management Program
- Care Transitions: Hospital to Home Program (H2H) - A complete description of this program has been included in Section C-4.

- Options Counseling

Title III-B: Support Services and AAA Administration

The list below illustrates areas in which Title IIIB funding is currently allocated and the percentage of the funding allocated to each area.

- Administration and Program Coordination- 10%
- Advocacy
- Legal services- 3%
- In Home services- 3%
    - Personal care and chore services
    - Respite
    - Adult Day Care
    - Home repair and modification

    - Case monitoring
    - Coordination of in-home volunteers
- Access services- 18%
    - Information and assistance
    - Screening
    - Case Management
    - Interpreting/translation services
    - Newsletter
    - Information for caregivers of elderly and those serving children
    - Assistance in gaining access to caregiver services
    - Public outreach/education
    - Transportation and assisted transportation
    - Geriatric assessment
    - Telephone reassurance
    - Friendly visiting

Other III-B Services

- Counseling
- Gatekeeper training
- Housing assistance
- Registered Nurse services
- Money Management
- Housing assistance

SDS has a Money Management Program in Benton County which is not currently funded by III-B discretionary funds; however, our goal is to support this program in the coming year and research the potential of expanding this service to Linn County.

Title III-C: Nutrition Services

Required services: Expertise of a dietician, compliance with dietary guidelines and nutrition education.

C-1: AAA Administration and Congregate Meals

C-2: AAA Administration and MOW

Local fund raising supplements the OAA monies with grants, meal site fund raising, dedicated funding and donations from the community. Senior Meals is a priority for the agency. We have never turned anyone away who needed a meal and

met the service priority. In fact, we have used fund raising dollars to create a small exceptions list for persons with disabilities who have short term need, but who are not 60 years of age or receiving Title XIX services.

Title III-D: Health Promotion and Disease Prevention- 23.6%

- Prescription medication education
- Information and counseling related to Medicare Part D
- Evidence based programs:
    - Care Transitions Intervention, H2H
    - Living Well with Chronic Conditions
    - Reducing Disability in Alzheimer's Disease (RDAD)

Care Transitions, H2H, is a priority for OCWCOG. The program is funded by III-D funds in cooperation with a grant from Samaritan Health Services Foundation. We are currently working with the Intercommunity Health Network Coordinated Care Organization (IHN-CCO) to provide additional contracted services in Linn County.

Title III-E-Family Caregiver Support Services and AAA Administration

- Information and assistance to family caregivers (including grandparents raising grandchildren)
- Counseling and organization of support groups
- Respite
- Supplemental services

SDS prioritizes these services and works collaboratively with community partners to co-sponsor training and workshops for caregivers. SDS has secured grant funds to expand respite services for family caregivers in all three counties over the last year and will continue to seek additional funds.

Title VII-A: Elder Abuse Prevention

- Co-organizer of local Multidisciplinary Teams (MDT) and Vulnerable Adult Services Teams (VAST), which meet monthly in all three counties
- Annual newsletter/newspaper campaign about elder abuse awareness
- Co-sponsorship of events with community partners about elder abuse prevention

Section B: Planning and Service Area Profile

B-1 Population Profile

In order to serve this region's population in an effective and efficient manner, this Area Agency on Aging (AAA) needs to bear in mind current demographics and emerging trends, which will effect the direction of services over the next four years. The following information is intended to create a profile of the region, the demographics and potential needs.

Characteristics of Seniors Living in Linn, Benton, and Lincoln Counties

Age

Reported by the 2010 United States Census, there were 52,348 seniors age 60+ in the three counties combined. This accounts for 21% of the total population of these counties.

Gender

In all three counties, 60+ females outnumber their male counterparts by at least 5%.

Race & Ethnicity

The United States Census categorizes "minority" as any person who identifies as African American, Hispanic or Latino, Asian American, Native Hawaiian or Pacific Islander, American Indian or Native Alaskan. According to this definition, the 2011 Census reported that 5% of our three county area's 65+ population is categorized as minority. This percentage represents 1,900 individuals.

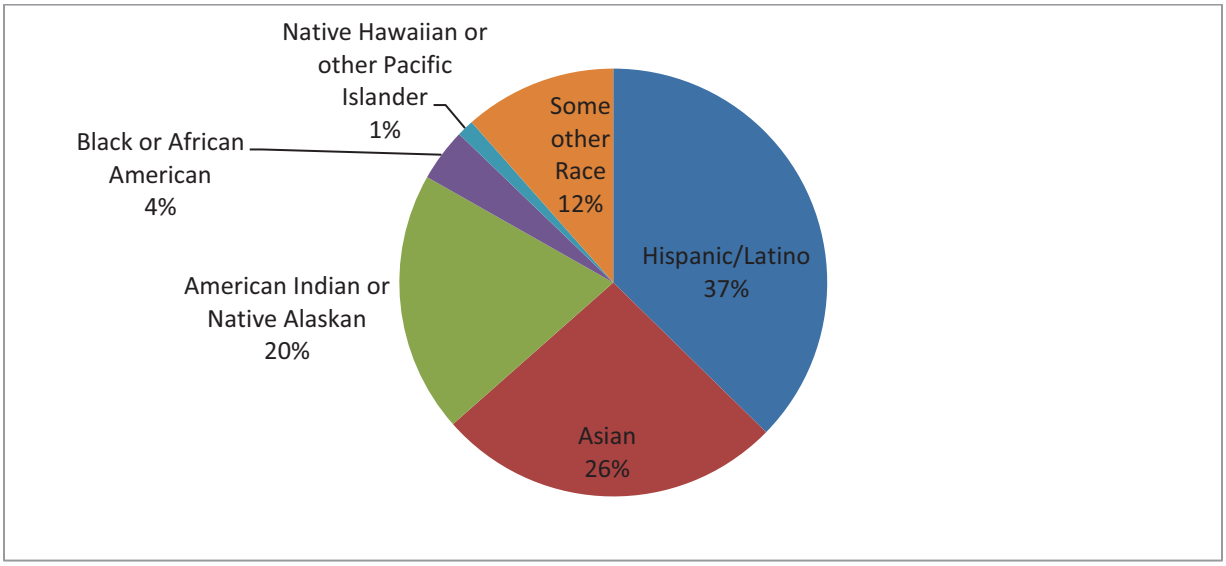
Characteristic	Oregon	Linn County	Benton County	Lincoln County
Total Population	3,831,074	116,672	85,579	46,034
60+ population	748,011 19.5%	24,366 20.9%	14,808 17.3%	13,174 28.6%
60+ Female	403,147	13,118	8,098	7,371
60+ Male	344,837	11,247	6,709	5,803
65+ White	502,399	17,410	9,798	9,615
65+ Hispanic/Latino	12,700	282	135	134
65+ Asian	12,056	102	221	63
65+ American Indian or Native Alaskan	3,739	136	39	115
65+ Black or African American	4,784	22	23	14

Characteristic	Oregon	Linn County	Benton County	Lincoln County
65+ Native Hawaiian or other Pacific Islander	449	12	5	2
65+ Some other Race	4,178	100	36	34
65+ 2+ Races	5,928	209	87	129
65+ Total Minority	43,834	863	546	491
65+ Siletz Tribal Elders	435	6	9	173
Native American Tribes represented in PSA with Title VI Programs	9	0	0	1-Siletz Tot Pop 4,677
60+ Speak only English	640,065	23,160	12,290	12,655
60+ Speak language other than English	48,460	605	705	315
60+ Speak language other than English & speak English “very well”	23,930	345	425	225
60+ Speak language other than English & speak English “well”	7,675	90	170	15
60+ Speak language other than English & speak English “not well”	9,205	125	105	75
60+ Speak language other than English & speak English “not at all”	7,650	45	4	0
Veteran total	345,700	12,641	6,263	5,472
Total Population Living Below Poverty Level	14%	15.6%	19.1%	16.2%
65+ Living Below Poverty Level	41,494	1,291	534	827
65+ Living Below Poverty Level & Minority	6,465	60	38	92

Characteristic	Oregon	Linn County	Benton County	Lincoln County
65+ Living in Rural Areas	N/A	24,366	4,851	13,174
Adults With Disabilities	466,074	18,397	8,262	8,219

*Data for ages 60+ was not available for all categories required.

65+ Ethnic Minorities in Linn, Benton & Lincoln Counties

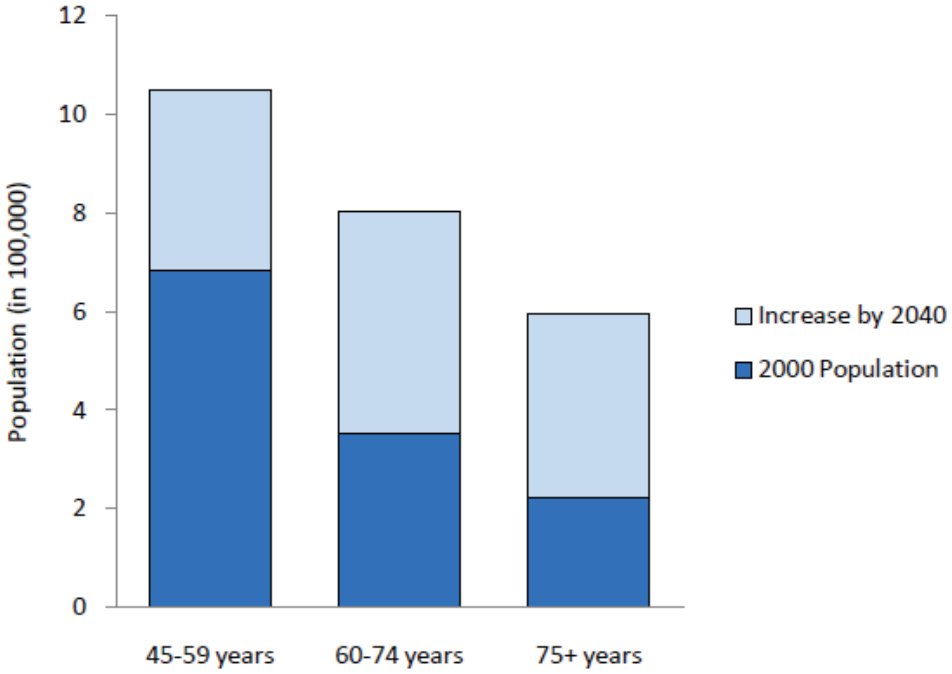


Senior Population Growth

The population of older adults in the United States is predicted to increase greatly over the next 30 years. This is due in large part to public health achievements such as cleaner water and vaccinations, as well as to the Baby Boomer generation entering their older adult years. The population of adults between the ages of 60 and 74 years of age in Oregon is predicted to increase from approximately 350,000 in 2000 to 800,000 in 2040. The population of adults 75+ in Oregon is predicted to increase from approximately 200,000 in 2000 to 600,000 in 2040. These increases are far greater than the expected typical population increases due to the generation known as the Baby Boomers. In Linn, Lincoln, and Benton Counties, together the population of adults between the ages of 60 and 74 years of age is predicted to increase from approximately 25,000 in 2000 to 45,000 in 2040. In the same three counties, the population of adults 75+ is predicted to increase from approximately 15,000 in 2000 to 35,000 in 2040. That means by 2040 the population of individuals 75+ in these three counties will grow to 233% of what it was in 2000. The following graphs depict this anticipated population growth.

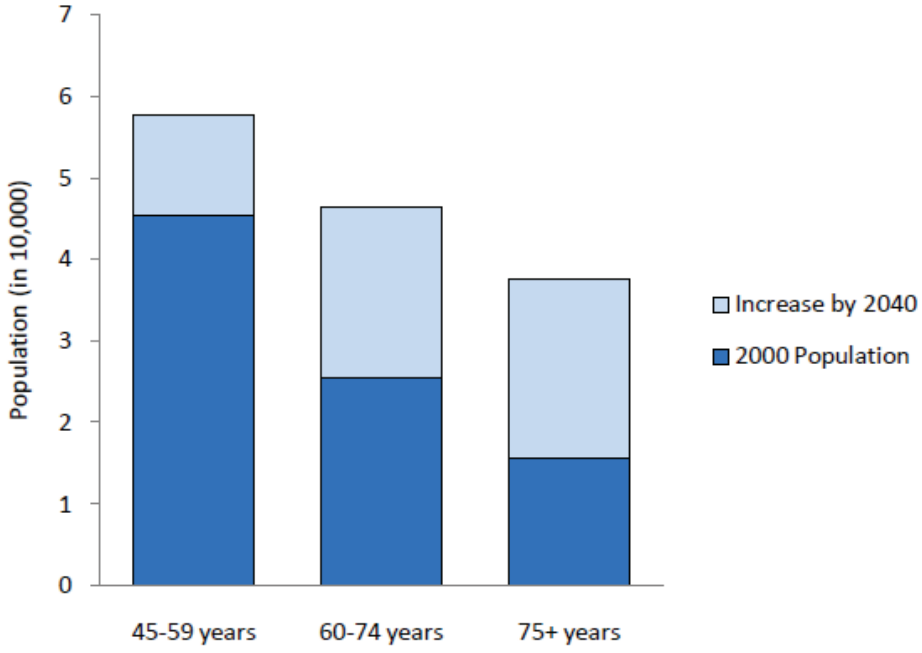
Oregon

Projected Population Growth, 2000 to 2040



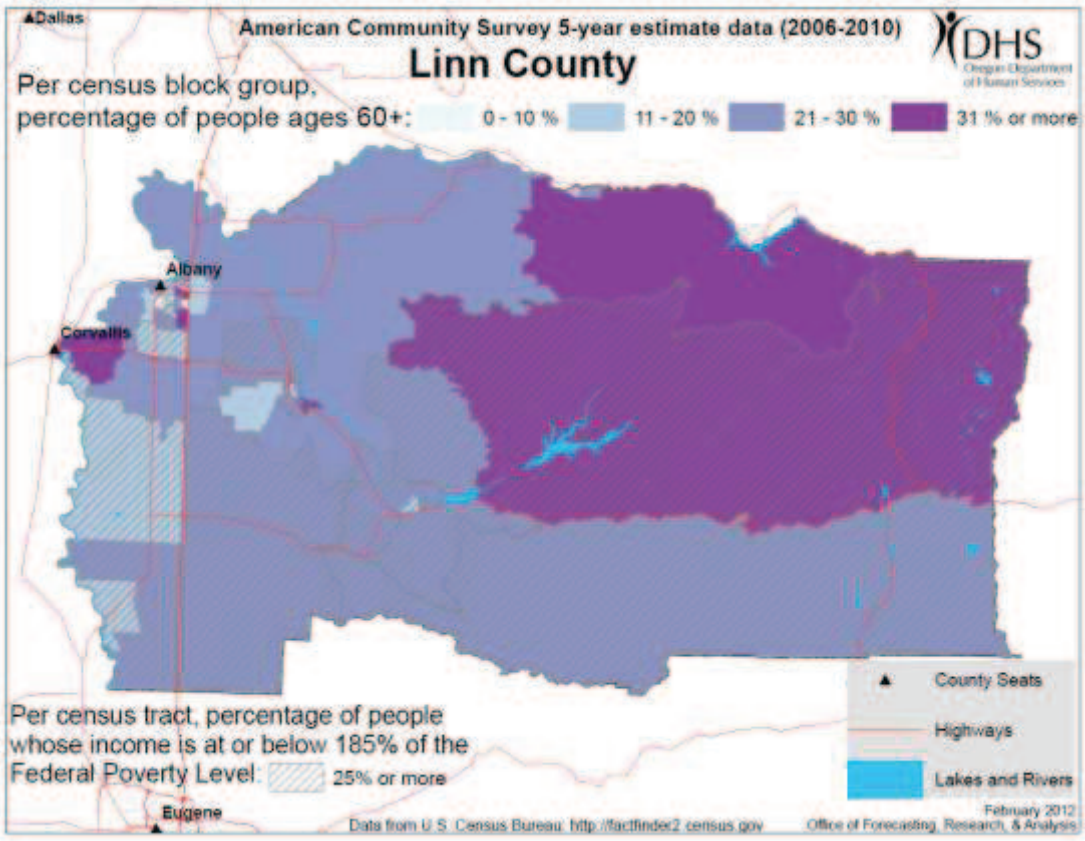
Linn, Benton & Lincoln Counties

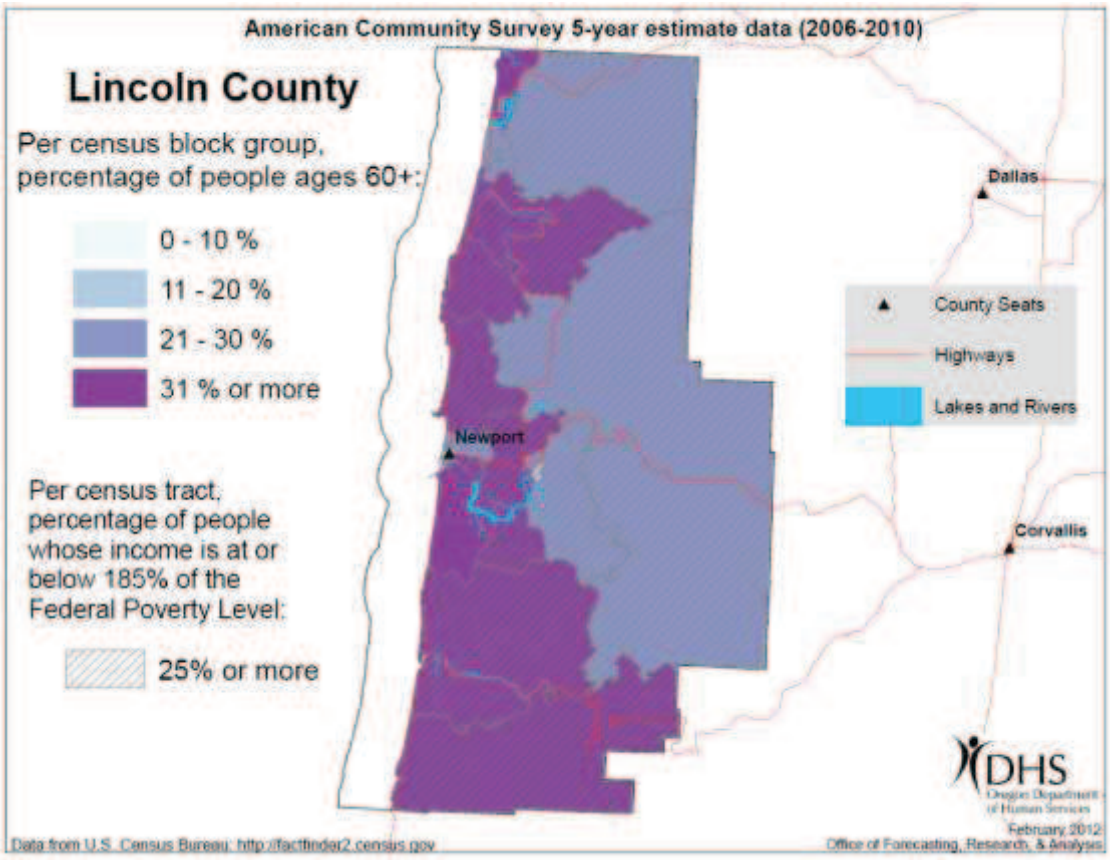
Projected Population Growth, 2000 to 2040

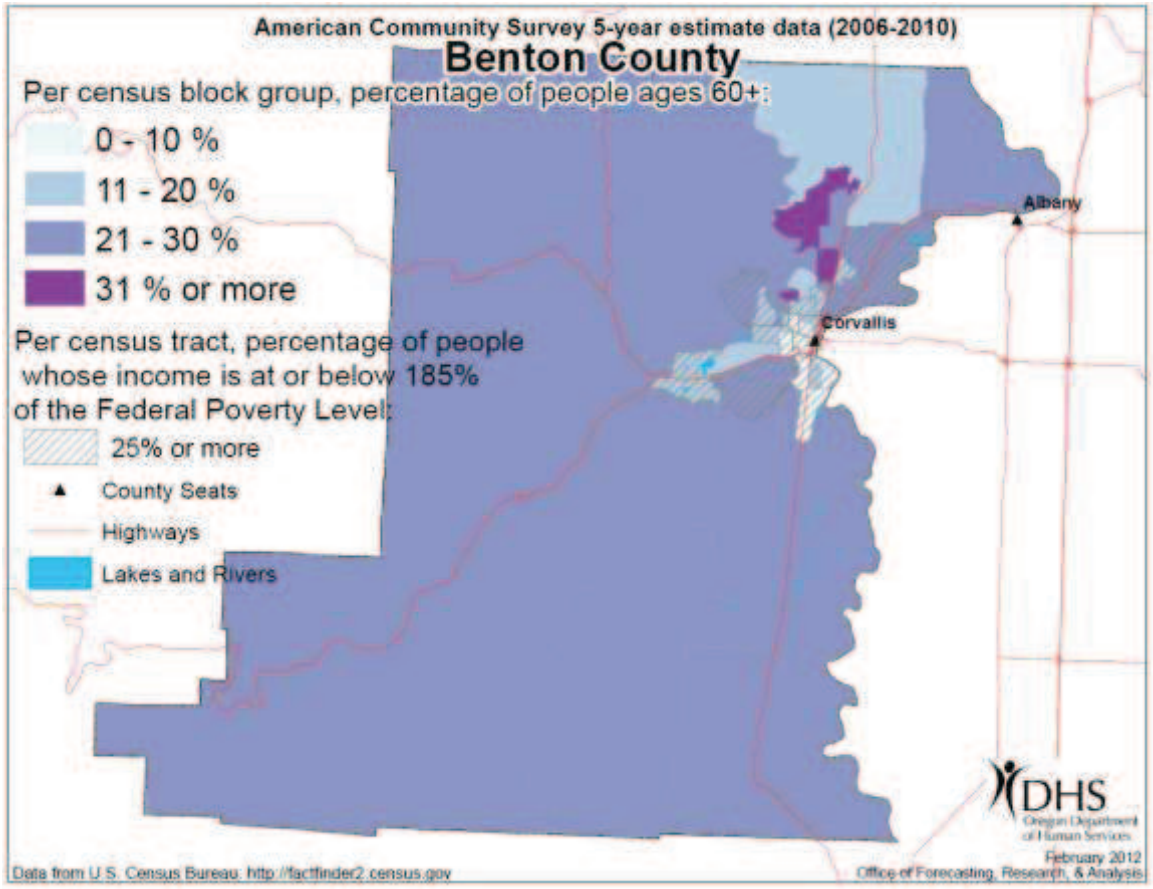


Along with this population growth, the need for long term services and supports and medical needs will increase. In Benton County, the number of individuals projected to have long term services and supports needs is predicted to rise from 4,424 in 2010 to 6,514 in 2020 to 7,797 in 2030. Projected increases in the number of seniors receiving Medicaid funded long term services and supports and other Medicaid assistance goes from 793 in 2010 to 1,168 in 2020 to 1,398 in 2030. In Linn County, the number of individuals projected to have long term services and supports needs is predicted to rise from 7,665 in 2010 to 9,844 in 2020 to 12,146 in 2030. Projected increases in the number of seniors receiving Medicaid funded long term services and supports and other Medicaid assistance goes from 1,374 in 2010 to 1,764 in 2020 to 2,177 in 2030. In Lincoln County, the number of individuals projected to have long term services and supports needs is predicted to rise from 4,102 in 2010 to 5,739 in 2020 to 7,037 in 2030. Projected increases in the number of seniors receiving Medicaid funded long term services and supports and other Medicaid assistance goes from 735 in 2010 to 1,029 in 2020 to 1,261 in 2030.

The following maps illustrate the distribution of our region's 60+ population and Federal Poverty Level by county. The crosshatched areas represent those where 25% or more of the population is at or below 185% of the Federal Poverty Level. The purple-shaded areas represent those where 31% or more of the population is ages 60+. However, from this data, conclusions cannot be drawn that that the group of individuals at or below 185% of the Federal Poverty Level are seniors.


Dallas
American Community Survey 5-year estimate data (2006-2010)
Linn County
DHS
Per census block group, percentage of people ages 60+:
0 - 10 %
11 - 20 %
21 - 30 %
31 % or more
Albany
Corvallis
County Seats
Highways
Lakes and Rivers
Per census tract, percentage of people whose income is at or below 185% of the Federal Poverty Level:
25% or more
Eugene
Data from U.S. Census Bureau: http://factfinder2.census.gov
February 2012
Office of Forecasting, Research, & Analysis


American Community Survey 5-year estimate data (2006-2010)
Lincoln County
Per census block group, percentage of people ages 60+:
0 - 10 %
11 - 20 %
21 - 30 %
31 % or more
Dallas
County Seats
Highways
Lakes and Rivers
Newport
Per census tract, percentage of people whose income is at or below 185% of the Federal Poverty Level:
25% or more
Corvallis
DHS
Data from U.S. Census Bureau: http://factfinder2.census.gov
February 2012
Office of Forecasting, Research, & Analysis



*Resources for this section include 4, 12, 14, 15, 16, 17, 18, 19, 24 &25 listed on the reference page.

B-2 Target Population

The following list of priority target populations within our three county service area has been developed by combining state required focal populations and those identified by the needs assessment process. Each of the groups identified below represent a group of people with unique needs, barriers that may prevent them from accessing services, are at higher risk for health issues, are at a higher risk to be isolated, and will require focused efforts by our AAA to assist them in getting their needs met. The target populations include:

- Individuals who are low-income and/or members of a minority group
- Seniors with language barriers
- Seniors who live in rural areas and are at-risk for isolation
- Adults, age 18 and older with disabilities
- Seniors who identify as Lesbian, Gay, Bisexual and Transgender (LGBT)
- Widowed senior women living alone over the age of 80
- Grandparents raising grandchildren
- Native Americans
- Individuals with Alzheimer's or dementia symptoms

The Aging and Disability Resource Connection (ADRC) Resource Specialists and Options Counselors make community presentations on an average of three times per month in our service areas. Oregon's poverty rate averages 8% overall. In the rural areas of all three counties we serve, the poverty rate is anywhere from 8-14%. Our staff meets with local self-sufficiency offices quarterly in order to identify low-income seniors, grandparents raising grandchildren and Hispanic and/or limited-English speaking adults who may benefit from Older American Act (OAA) programs. All agency brochures are available in our offices and at presentations in both English and Spanish. The agency is evaluating the need for information in Russian, due to the presence of Russian speaking individuals in Linn County. Currently, we have interpreter services available for Russian speakers.

Oregon Cascades West Council of Governments (OCWCOG) participates in planning efforts, workgroups, community forums and coalitions that represent and develop programs and policy for target populations. Through these partnerships we identify individuals in our service area who are vulnerable, isolated, and financially in need. Some of these groups include the Healthy Aging Coalition, Multi-Disciplinary Teams (MDT), the Vulnerable Abuse Service Team (VAST), Self-sufficiency, local Senior Centers, the Linn-Benton Senior Resource Network, the Homeless Connect program and the Heart-to-Heart Homeless Coalition. The Heart-to-Heart Homeless Coalition plans a homeless fair annually with community

service groups, which is cosponsored by OCWCOG to provide information and assistance.

Through our Memorandums of Understanding, contracts with partner agencies and volunteer organizations (Appendix G), we agree that they will refer consumers who are identified as low income, minority, at-risk for isolation, or whom are generally underserved due to their socio economic status to our ADRC for information and assistance.

Because the majority of our three county service area is categorized as rural by the United States Census, rural citizens have always been a major target population for SDS. Our Meals Program has 11 meal sites throughout the counties, the majority of which are located in rural areas to meet the growing needs of seniors who are homebound and at risk for isolation. By working with health clinics, churches and an array of volunteer programs, we strive to identify and serve older adults and individuals with disabilities living in rural areas. One way OCWCOG combats the challenges associated with living in rural areas is by providing medical and non-medical transportation for low-income seniors and younger disabled clients who are served in any program that does not provide transportation through Special Transportation Grant Funding in Linn, Benton and Lincoln Counties.

A growing population of Hispanic and limited-English speaking individuals reside in our service area. These are vulnerable populations which ADRC staff, including Options Counselors, will focus on while planning outreach and services. One goal of this nature is to expand outreach in Newport to Centro de Ayuda, a cultural "help center" for the Hispanic population in our coastal service area. The Options Counselor has taken Spanish translated ADRC and Options Counseling information to the center and makes regular contact with the Executive Director. We conduct outreach activities through our Older American program staff in all three counties to: schools, businesses, healthcare clinics, partner agencies, churches and volunteer organizations. Many local churches have staff and/or volunteers providing advocacy and support for minority parishioners, with whom our agency can provide information and coordinate services for minorities.

As a Type B Transfer Agency serving both seniors and people with disabilities, we have offices in Albany and Toledo, and to meet the needs of a large, younger disabled population in Benton County, we have an office in Corvallis. Our staff, as part of the Corvallis office, includes our Benton County Veterans Service Officer. Our Corvallis office, which is near Oregon State University, increases our visibility to engage younger disabled adults. Because of their work with this young disabled population, our Medicaid and ADRC staff has familiarized themselves with the

needs of younger citizens, which connects our agency to community resources with which we would not otherwise interact.

In a 2003-2006 study conducted by the State of Oregon, 3% of females and 2% of males identified as gay, lesbian or bisexual. In 2009, Benton County Health Department sponsored transgender training for medical professionals on the heels of a 2009 Benton County survey that identified health risks such as depression, PTSD and anxiety in LGBT individuals. The Friendly House, a LGBT focused Portland organization reports:

> LGBT older adults face challenges that their heterosexual counterparts do not. For example, the effect of historical and present-day social stigma and prejudice often cause LGBT older adults to not seek care or services when needed. This stigma can also leave LGBT older adults and seniors isolated or having to face the impossible decision to go back into the closet to seek care, services, or housing. Whereas many older adults and seniors turn to families for care or support, LGBT older adults are more likely to live alone or have inadequate family support networks. Lastly, LGBT older adults and seniors face unequal treatment under laws, programs and services. All together these challenges make it more difficult for LGBT older adults to achieve three key aspects of successful aging; financial security, good health and health care, and community support and engagement.

The organization, Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE) asserts in their Strategic Plan 2008-2012, that older adults who identify as LGBT may be five times less likely to access needed health and social services because of their fear of discrimination. This illustrates the importance of developing outreach and service delivery methods that alleviate such fear and are culturally sensitive to this growing population.

In order to engage and serve a greater number of LGBT individuals, we will be communicating with SAGE, and their advocates in Multnomah County, along with Gay individuals and their advocates in the larger metropolitan areas. Our goal is to partner with the larger organizations to present community forums in our counties with focus groups to help identify the needs of the LGBT communities, starting with Benton County. The State Home Care Commission is sponsoring training for homecare workers on the registry regarding the needs and diversity of LGBT. The training will be a collaboration of efforts from AARP, Diversity Council, and the Friendly House in Portland. Our OAA case management staff will attend this training and encourage LGBT clients to hire and ask home care workers if they have taken, or would be interested in taking, this training.

Along with population priorities designated by the Older American Act, we focus on additional groups, Native Americans who are a part of the Confederated Tribes of Siletz, the high percentage of widowed senior women living alone over the age of 80 and grandparents raising grandchildren. Through the development of our ADRC, we are preparing to provide information, assistance and Options Counseling to a growing number of Baby Boomers over the next four years. It is imperative that we organize our services to accommodate the older adult population increase expected over the next 30 years. By 2040, the population of individuals 75+ in our three county area is expected to grow to 233% of what it was in the year 2000.

The Confederated Tribes of Siletz has a major presence in Lincoln County, and has tribal members living in Benton and Linn Counties. Lincoln County is also home to tribal members of the Coos, Lower Umpqua & Siuslaw tribes. A primary focus of our agency is to partner in activities with the Confederated Tribes of Siletz through the ADRC, Senior Meals Program and Family Caregiver Support Program. We currently provide congregate meals in Siletz.

Individuals with Alzheimer's or dementia symptoms represent a growing target population for our agency. Alzheimer's disease is the most common type of dementing disease afflicting the elderly and is a challenging journey, not only for the person diagnosed, but also for their family members and loved ones. Approximately two thirds of those suffering from this disease are cared for at home by family, usually a spouse. Through the Family Caregiver Support Program and Oregon Project Independence, we specifically serve this population and their caregivers. We have partnered with the Linn Benton Senior Resource Network to stay connected with hospice, home health and local living facilities specializing in Alzheimer's care. In addition, we are discussing opportunities to support evidence based programs such as STAR-C and the Reducing Disability in Alzheimer's Disease (RDAD) Project.

*Resources for this section include 2, 8, 11, 19, 21, 23 &24 listed on the reference page.

B-3 AAA Administration and Services:

Service System

Core functions of Senior and Disability Services (SDS) include managing the Medicaid program, managing Older American Act (OAA) funds and program services, developing resources to meet the needs in our region, advocacy and managing the Aging and Disability Resource Connection (ADRC) as a front door to services and supports.

The following section identifies the individual services or service components that our AAA provides with OAA funding as well as funding from local sources.

Older Americans Act and Other Support Services:

1. Information and Assistance- Help individuals, families and community members connect with needed services as well as providing information on community resources through the ADRC.

2. Outreach & Public Awareness- ADRC Resource Specialists and Options Counselors present information about programs and services for seniors who need social, health or financial assistance and how to gain access to services. Presentations are made 1-3 times per month to hospital groups, civic organizations, local health fairs, senior centers and volunteer organizations.

   Options Councilors provide services to individuals and families who are experiencing a crisis and/or want to explore long term services and supports planning. There is a focus on those at risk for having to leave their home related to a healthcare crisis or ongoing care needs. The Options Counselors complete an assessment of need, provide resource education and counseling and facilitate client-centered action planning with consumers and their families during a face-to-face visit, usually in the home. Options Counselors assist in creating a client driven action plan, provide short term assistance and follow-up with individuals and families.

3. Legal Assistance- SDS contracts with OAA funding in all three counties to provide 400 hours of legal aid services to persons 60 years of age and older. A complete copy of this contract has been included as an attachment. Clients call Legal Aid Services of Oregon to make appointments with an attorney. Client appointments are scheduled for one day every month at Senior Centers in Sweet Home, Albany, Lebanon, and Corvallis. In Lincoln

County, appointments are made at the Newport office of Legal Aid Services of Oregon or at the client's home. In Linn and Benton Counties, appointments are scheduled at the Albany office of Legal Aid Services of Oregon, in clients' homes, at nursing homes or telephone appointments as necessary.

4. Congregate Meals- The Meals Program provides a hot, nutritious midday meal along with social and educational activities at meal sites throughout the counties. This program helps prevent isolation and malnutrition in older adults, while they congregate to share meals and continue to feel involved in their community. Recipients are asked for a donation, but it is not required.

5. Home-Delivered Meals- The Meals Program provides nutritious hot meals to homebound older adults and people with disabilities. Frozen meals are provided for weekends and holidays for those at the highest risk. Emergency meal boxes are provided each fall to accommodate unforeseen situations. A value added to the "Meals-on-Wheels" program is a friendly volunteer knocking on the door of the most vulnerable persons in our community to deliver a meal.

6. Nutritional counseling/education- As a part of the Meals Program, we provide nutritional education to our program participants. This is done as a means to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health information. The information on nutrition is delivered to program participants, caregivers in a group or individual setting overseen by a dietician or individual of comparable expertise.

7. Case Management- SDS Case Management service provides a holistic and comprehensive assessment of the physical and other needs of older adults, while working with them and their families to identify their care needs. Case management services include developing service plans combining agency managed in-home services, connecting older adults with other community resources and providing ongoing monitoring and assessment to insure that the service plan is appropriate and effective.

8. Elder Abuse Prevention- SDS continues its campaign to prevent abuse before it begins. Along with the utilization of brochures and flyers in English and Spanish, educational events are organized to raise the

consciousness of the public and potential abusers relating to elder abuse. SDS staff participates in the Vulnerable Adult Services Team (VAST), a group of law enforcement, district attorneys, legal aide attorneys and adult protective services workers. The Team spends time staffing individual cases that are being worked on as well as devotes time to discussing a range of community concerns and developing prevention strategies.

9. Family Caregiver Support Program (FCSP) – The FCSP assists unpaid family caregivers by providing program supports to ease family caregiver stress and increase coping skills. The goals of this program are to assist family caregivers to successfully meet the challenges of their care giving role and stabilize care given within the home through continued support while forestalling placement in a higher level of community care.

   Respite care is provided to family caregivers along with general support and information, connection to local support groups, counseling, homemaker services, supplies and assistance devices. One example of respite care provided is transportation and attendance at the Grace Adult Daycare Center in Benton County.

   Grandparents and relatives who are age 55 and older, raising a blood related child are also eligible to receive assistance through the program. Provision of scholarships for after school and/or outdoor programs/camps are examples of the supplemental services provided to grandparents in the program.

   The FCSP provides caregiver training to caregivers and their families to support and enhance the care giving role. Powerful Tools For Caregivers is an educational class series supported by the FCSP's in Linn, Benton and Lincoln Counties. Our FCSP coordinators are both fully trained to facilitate these classes.

10. Oregon Project Independence (OPI) – OPI provides case management and in-home care services for individuals who are not Medicaid eligible (except for Food Stamps, Qualified Medicare Beneficiary) and are 60 years or older or under 60 years and diagnosed as having Alzheimer's disease. Services are authorized based on individual client needs and may include in-home care, adult day care services, respite and nursing services.

11. Advocacy- SDS provides opportunities for consumer advocates to work with program issues as well as public policy issues with local and state policy makers. The AAA also works with policy issues and represents the interests of older adults and people with disabilities as well as their caregivers at local, state and national levels.

12. Registered Nurse Services- Contract services are provided through OAA funding. Contract Nurse Services are intended to provide consultation with consumers and caregivers about medication management, chronic disease management, offer resources for caregiver training and assist with making contact with their primary care physician as needed.

13. Medication Management Screening and Prescription Drug Education- This services is intended to prevent medication errors and adverse drug reactions through individual or group medication reviews. Each year at the Living Well Expo, sponsored by the Oregon Cascades West Senior Services Foundation, pharmacists offer attendees the opportunity to consult on medication management concerns such as side effects of prescription medications and adverse drug interactions.

14. Education- Provide a quarterly informational newsletter entitled "Generations" in partnership with local newspapers in each county. The newspapers on Albany, Corvallis and Newport are partners in this effort. In addition, regular newspaper articles are written and published monthly on issues important to the residents of our region.

15. Money Management- The Money Management Program assists with financial tasks for seniors who need support with their personal finances (i.e. banking, transactions, paying bills, taxes) and are at risk in the community. This service is provided in Benton County.

16. Volunteer Services- Oregon Cascades West Council of Governments (OCWCOG) provides an array of opportunities for older adults and people with disabilities to stay involved in their community. Volunteers participate in decisions that affect them at a State and local level and provide input regarding needed services and programs. Volunteer experiences also include: meal site volunteers, drivers for home delivered meals, Retired Senior Volunteer Program (RSVP) volunteers in Lincoln County, and both the Senior and Disability Services Advisory Councils.

17. Retired Senior Volunteer Program (RSVP) – RSVP in Lincoln County is the coordinator of volunteer opportunities in a wide array of settings for older adults. In addition to these volunteer placements, the RSVP Program supports programs that provide regular friendly telephone calls and/or visits to physically, geographically or socially isolated persons to determine if they are safe. Other RSVP services include the Grab Bar Program for those who need a grab bar installed, Trans-Med Program which matches volunteers with older adults in need of a ride to medical appointments, and Senior Health Insurance Benefits Assistance (SHIBA) which helps older adults manage their benefit programs such s Medicare and the Part D Prescription Drug Assistance Program..

18. Transportation- The AAA provides access to medical and non-medical transportation for low-income seniors and disabled clients. Special Transportation Grant Funding in Linn, Benton and Lincoln Counties is applied for on an annual basis to offer bus tickets to use for those without access to a car and vouchers for gasoline to travel to medical appointments.

19. Program Coordination & Development- Provide administrative functions required to implement planned services, negotiate and maintain required contracts and records.

Title XIX and State Funded Services

The following services are provided through a combination of community partners and OCWCOG, to individuals age 65 and older and persons with disabilities under the age of 65 who qualify based on income and resource criteria and impairment.

1. In-Home Care- OCWCOG provides assistance with recruiting, hiring, and paying an in-home provider (hourly or live-in 24/7) who is employed by the person receiving assistance. In-home care workers help with light housekeeping, meal preparation, bathing, and other personal care needs to enable people to remain in their own homes.

2. Adult Foster Care- This care setting provides 24-hour care in a private home that is licensed for up to five residents. The AAA is responsible to conduct licensing activities for these settings on a regular basis.

3. Residential Care Facilities- This care setting provides room and board with

24-hour supervision and is licensed for six or more residents. These facilities provide assistance with physical care needs, medication monitoring, and some planned activities. The AAA works with the state to insure quality care in these facilities.

4. Assisted Living Facilities- This care setting provides private apartments with meals, housekeeping, and physical care as needed. They are licensed for six or more residents. The AAA works with the state to insure quality care in these facilities.

5. Adult Foster Home Licensing- OCWCOG inspects and monitors adult foster care facilities to ensure they meet State standards for licensing.

6. Adult Protective Services (APS)- SDS's APT investigates complaints of abuse, neglect or exploitation of older adults and people with disabilities. APS takes appropriate action to protect those living in the community, and reduce risks in their living situation.

7. Pre-admission Screening & Diversion/Transition- OCWCOG has a team of trained professionals who assess the needs of older adults and people with disabilities to determine if there is a need for nursing facility care. Screeners take an active role in identifying alternate placements and resources needed to successfully divert and transition older adults and people with disabilities from nursing facility placement. Individuals and their families are assisted in obtaining care that is most appropriate for their needs.

8. Nursing Facilities- People who are highly impaired functionally may qualify for nursing facility care. Nursing facilities provide skilled care, rehabilitation, and end-of-life care. Licensed nursing staff is required on site 24-hours per day. The AAA staff work with the facilities and the state to insure quality care for the residents.

9. Case Management- OCWCOG provides a professional assessment of unique needs. Case Managers work with clients and their families to identify the most appropriate level of care and follow through to assure that care plans are maintained. The AAA staff conducts the assessment, create a care plan and reassess on an annual basis to determine if care needs have changed. Our staff determines eligibility for services through the Medicaid program.

10. Food Benefits- OCWCOG staff determine eligibility for the Supplemental Nutrition Assistance Program (SNAP) and issues monthly benefits to those eligible.

11. Medicaid- OCWCOG Eligibility staff enroll Medicaid eligible clients (receiving waivered or long term services and supports, or if they are receiving SSI) so that they can receive a Medical ID Card that pays for all medically necessary expenses. For clients not receiving waivered or long term services and supports, SSI, Qualified Medicare Beneficiary (QMB) or Specified Low Income Medicaid Beneficiary (SMB), eligibility is determined. Under the QMB program, a client is eligible for the payment of their Medicare Part B premium, annual Medicare deductibles and 20% Medicare co-pay. Under the SMB program, a client is eligible for the payment of their Medicare Part B premium.

12. Oregon Health Plan (OHP) – OCWCOG determines eligibility for medical benefits for qualifying older adults and people with disabilities under OHP.

13. Special Needs Equipment and Adaptation- OCWCOG provides medical devices or modifications to promote independence, access, and safety in the home and community for people with disabilities and older adults.

B-4 Community Services Not Provided by the AAA

As a Type B Transfer Area Agency on Aging (AAA), Oregon Cascades West Council of Governments (OCWCOG) has the responsibility to manage Older American Act (OAA), Oregon Project Independence (OPI) and Medicaid long term services and supports. Over the years, our organization has had the experience of piloting new programs, reorganizing existing services to modernize what we are able to offer to the community and has a strong commitment to increasing fundraising and grant writing to supplement critical services such as the Senior Nutrition Program.

Our organization has also been hurt by the service cuts, budget reductions, elimination of what were once thought of as critical safety net programs and a lack of cost of living increases through our contract with the State. This has been accompanied by a lack of increased funding through the federal OAA. We have weathered the cuts, restoration and program freezes of the OPI Program as well as the issues cited above.

The Oregon experience is not unique. The economic uncertainties of the last five years have damaged most of the services that are paid by federal, State or local tax revenues. Even prior to the economic recession, the Oregon system of funding services that supports older adults and people with disabilities did not keep up with need in the community or the cost of doing business either as a not for profit or regional government.

The creativity of our organization, the resiliency of our staff and management and the single focus on providing the highest quality services possible under these difficult and painful financial times, is testimony for the commitment that OCWCOG has to serve our region.

Our organization has managed to support many key programs during these difficult times. We rely upon partnerships and grants to assist in service delivery and be able to move forward with new projects. The next four years are not likely to be different from the last several years. Economic stagnation, if not full and ongoing recessionary pressure, coupled with the inability for Oregon to create jobs will make this period a time where we hang onto the gains we have made and continue to work with partnerships and grants to make small steps forward. The changing demographics of our communities and the increases in the needs of our current and future clients will make for challenging times.

As an AAA we are limited by the constraints mentioned, but believe that as opportunities present themselves, we will use them to bring new ideas or pilot

projects to the region or a portion of the region. This is our mission and our vision of who we are and what we represent to the communities we serve.

The following is a description of the areas in which we provide services or partnerships as well as areas that we would like to expand or initiate given the opportunity. This is in part a statement of what our community needs and also a statement of what we believe is possible within limited State and federal resources.

Transportation – The transportation issues within our three counties rise to the surface when discussed in public forums. While there are fixed route resources within the cities of Albany, Corvallis and Newport, the ability to get around the community during weekends and evenings is limited without family, friends or neighbors to help. The partnerships in the community that provide current transportation resources are significant. While the AAA is not a resource to solve these issues, we are in a position to achieve small improvements through advocacy and working to provide a voice for those unable to advocate for their transportation needs. We have been working with community partners to understand how we can assist in the planning around getting older adults to farmers' markets. Discussions with special transportation planners and the organizers of the markets show promise in achieving our goals.

Elder Abuse Awareness and Prevention – Elder abuse is an ongoing and troubling issue in all of the communities in the region. Our Adult Protective Service (APS) work is a critical component to investigating and working with local partners on complaints, suspected abuse and neglect. In addition to our staff work through the APS program, we are involved with our partners in staffing difficult cases, problem solving coordination issues and providing public education and training of providers in the community. There are gaps in the system that go beyond our ability to solve. We will continue to work on these issues and create public education and intervention strategies to support those in need.

Independent Living Centers (ILC)- ILCs are 501(c)(3) non-profit organizations run and controlled by persons with disabilities. They are non-residential, community-based centers where people with disabilities can receive assistance with an array of independent living services from people who have had similar experiences living with a disability. The centers serve people with all types of disabilities and, with some exceptions, do not charge for their services.

The Mid-Willamette Valley does not have an ILC funded by State and federal funds. Over the years there have been attempts to create the core group of advocates as well as a funding base to support a program, but the gap remains. In Lincoln County, a small nonprofit Progressive Options, works to provide a limited

service to people with disabilities. Our staff in Lincoln County work to coordinate on service issues and requests for help within our ability to do so. Without a focal point for the needs of people with disabilities, we do what can be done through the Aging and Disability Resource Connection (ADRC) as well as working on benefits counseling and benefits coordination which are two of the biggest issues we encounter. When the Department of Human Services (DHS) funded Employment Initiative was available, we were able to assist with additional services such as preparing resumes, interviewing skills and job searches. This is a gap for those with disabilities who have difficulties finding support and advocates.

Health Systems Issues – There are many issues in this area that are going to need careful attention during the next several years. The previously described work with the Coordinated Care Organization (CCO), along with the experiences of care transitions and health navigator roles that we hope to develop, are a key part of how the system develops and reflects the needs of older adults and people with disabilities. As the CCO develops over the next two to three years, our role will be to coordinate and provide transition services in a system of care that helps emphasizes the prevention and early intervention principles of transformation. We acknowledge the challenges and financial difficulties in supporting care systems which intervene for those on Medicaid.

Education and Counseling Programs – OCWCOG is the sponsor of Retired Senior Volunteer Program (RSVP) in Lincoln County. As a part of our responsibilities, we manage the Senior Health Insurance Benefits Assistance (SHIBA) Program within that contract. With the changes described in the previous section, the SHIBA role will need to expand as a support service to the CCO. There is also a need to expand the Senior Peer Counseling Program to the entire region and support the CCO as they begin to grapple with the large unmet needs of older adults who need behavioral health interventions and someone to talk to as isolation, grief and loss build over time. In addition, we have started a small Money Management Program in Benton County. The lack of financial support for this program makes it difficult to operate. We are only able to operate because of a volunteer Program Coordinator. With additional support, we hope to be able to extend the program to the entire region, as well as add the representative payee service to the bill payer service.

Alzheimer's and Dementia Supports – While we have a successful Family Caregiver Support Program (FCSP) and multiple community support groups, there is a growing need for respite and training services for caregivers. We are exploring the potential of starting a small STAR-C project in the region to assist those who may be able to benefit from this evidence based intervention. STAR-C is a

program designed to help caregivers reduce or eliminate their family member's problem behaviors. A trained STAR-C consultant makes eight home visits to work with the caregiver. The consultant follows up with four phone calls after the visit ends. We are also part of the Reducing Disability in Alzheimer's Disease (RDAD) Project through the University of Washington. The RDAD program is designed to help teach older adults who may suffer from memory problems, how to do simple exercises to improve overall health. The program teaches family members about symptoms to watch for and how to care for individuals with memory problems. This program hopes to improve the ability of the person with dementing illnesses to carry out activities of daily living while also helping family members provide assistance to their relative. We will have staff trained in this model and will work to spread the impact of using specific exercise programs to slow the disease process of Alzheimer's and dementia.

Section C: Issue Areas, Goals and Objectives

Oregon Cascades West Council of Governments (OCWCOG), in cooperation with the State of Oregon, has identified the Issue Areas for our region's target population. Issues Areas are those issues which have been identified by this Area Agency on Aging's (AAA) planning process as requiring attention and on which we will focus special effort during this four-year plan period. Issue Areas address national and state concerns and priorities identified in the Older Americans Act (OAA), the OAA State Plan and the State Agency's strategic plan.

1. Issue Area: Family Caregivers

Profile:

The Family Caregiver Support Program (FCSP) assists family caregivers in their expanding roles by providing program components that will ease family caregiver stress and increase coping skills. Goals of the program are to: assist family caregivers to successfully meet the challenges of their care giving roles; stabilize care giving within the home through continued support; and forestall placement in a higher level of community care. There are currently 141 individuals, throughout Linn, Benton, and Lincoln Counties, enrolled in our FCSP.

The FCSP caters to non-paid caregivers caring for individuals over the age of 60, grandparents over the age of 55 caring for a grandchild 18 years of age or younger, and adults of any age caring for an individual of any age with Alzheimer's or a related disorder. FCSP coordinators work with many community partners and other Senior and Disability Services (SDS) programs to find solutions to what can seem like overwhelming situations. Our FCSP is often a resource for Adult Protective Services (APS) staff by helping support at risk families caring for seniors and individuals with disabilities in our communities.

The most prominent goal of the FCSP is to take care of caregivers while they take care of others. The designation of program coordinators for the FCSP in each SDS office has assisted in raising public awareness and visibility of the program, increased utilization of the program, and made it possible to offer a more coordinated set of community activities.

The FCSP has made a concerted effort to provide critical services at no cost to unpaid caregivers caring for adults with functional disabilities or grandparents and other relatives who are raising children. We recognize what a huge responsibility it is to take care of a loved one and how difficult it can be. Without adequate support,

caregivers may end up with compassion fatigue. A 2006 study by Zarit, estimated that 40-70% of family caregivers have clinically significant symptoms of depression, with about ¼ of those meeting the diagnostic criteria for major depression. This program links caregivers with helpful support and resources to combat such serious concerns.

Referrals to the FCSP are received through our Aging and Disability Resource Connection (ADRC) and directed to our coordinators. These referrals come from a variety of partner agencies and members of the community. It is then the coordinator's responsibility to call the caregiver and inquire as to whether they would like information about the program. If an individual is interested in the FCSP, coordinators set an appointment to meet, usually in the caregiver's home. During the initial appointment, coordinators provide a caregiver bag containing resources, and may offer self care books. During the initial home visit, the coordinator completes an assessment and evaluation of the needs of the family caregiver and care recipient.

Coordinators are certified Powerful Tools for Caregivers facilitators. This is a support and education group that lasts six weeks, meeting once per week for sessions of 2.5 hours. This gives caregivers the opportunity to gather with others in the community in similar situations. Over the course of this class, caregivers trouble shoot, learn coping techniques and skills and form connections.

One objective of the FCSP is to help caregivers acquire the equipment, supplies, home repair and adaptations needed to provide care to the best of their abilities. Generally, coordinators try to link individuals with durable medical equipment providers to meet these needs. A portion of FCSP funds are allocated to help or share the expense of medical equipment and supplies such as wheelchairs, walkers, hospital beds, incontinence products, masks, cleansing cloths or gloves. Funding can also be used to make minor home repairs or modifications such as wheelchair ramps, handrails or bath bars, emergency response systems and pay for Meals on Wheels (MOW); equipment and services which makes care giving more efficient and successful.

The FCSP often partners with community agencies to host educational and motivational activities for caregivers. In August of 2012, we will be partnering with the Alzheimer's Network of Oregon to host a conference including a presentation by Dr. Winningham from Western Oregon University. This November our FCSP will join community partners to host their 4th annual Family Caregiver Recognition Day in celebration of National Caregiver Month to support caregivers and promote self care. Grandparents and other relatives raising grandchildren are

invited to an annual seminar in Marion County, which provides information focused on raising grandchildren and the option of a weekend retreat, *A Gift of Time*, which provides respite care.

The seven core elements of the FCSP were thoroughly considered when planning the program.

1. The first element of information services and group activities is accomplished by our knowledgeable coordinators who consistently provide educational information and brochures for community services relevant to each client. Our Lincoln County coordinator facilitates two Senior Services Networking groups in the coastal region and visits her county's meal sites once per month to promote the program and keep connected to community partners.
2. The second element, specialized family caregiver information, is addressed during the first face-to-face visit and on an as needed basis thereafter.
3. The third element of the FCSP, counseling, is something that can be paid for with program funding and is referred out on an as needed basis. Coordinators are always willing to help caregivers navigate their health insurance options to help pay for services.
4. Training, the fourth element of the program is also handled individually. Multiple trainings are listed above, but coordinators are also interested in helping caregivers get specific training they need. Caregivers have participated in a variety of trainings from CPR to Powerful Tools for Caregivers, to an array of Alzheimer's care training.
5. Our FCSP coordinators prioritize the promotion of support groups to caregivers they work with, the fifth element. In partnership with the Samaritan Health Services, our Lincoln FCSP coordinator facilitates two Caregiver Support groups. FCSP connects clients with support groups to share experiences and problem solve with others in their community going through similar experiences. Such support groups help individuals realize that they are not alone.
6. The sixth element, respite care services, is an incredible resource of the FCSP. By providing caregivers a break, whether in or away from the home, it increases the quality of care they are able to provide. A break from continuously caring for a loved one can be refreshing and energizing. Through this program, respite providers are able to provide personal care, meal prep, and transportation as well as companionship. Benton County is home to one of the few adult day services in Oregon, The Grace Center. This is a service and facility strongly encouraged and supported by FCSP coordinators. Our AAA contributes funding to the Grace Center and

conducts annual evaluations to ensure the best possible care for clients. For grandparents caring for minor relatives in particular, respite care has come in the form of paying for summer camp or similar activities for their grandchildren. This provides an enriching experience for those whom they care for and time off for the caregiver.

7. The seventh element, supplemental services, includes a wide range of activities. Some examples are payment of monthly monitoring fees for an emergency response system, home delivered meals, assistance buying school clothes and caregiver massages.

The National Alliance for Caregiving in cooperation with Evercare reported in 2009, the value of unpaid services family caregivers provide, caring for older adults, equals approximately $375 billion a year. That is nearly double the amount spent on homecare and nursing home services combined ($158 billion). This is something we cannot ignore.

Problem/Needs Statement:

A Caregiver Support Survey was conducted in 2010 to gather feedback and identify existing gaps in service for those being served in Linn and Benton Counties. Results from the survey were overwhelmingly positive and encouraging of this program's potential. 57% of those who received respite care commented that they needed a longer break. Since the survey, this has become a focus area in the program. Caregivers were given a chance to comment on what they experience mentally and emotionally throughout the care giving process. These answers ranged broadly from joy to exhaustion and everything in between. When asked what is most helpful to caregivers, the vast majority prioritized respite care and encouragement/emotional support at the top of their list.

Because the FCSP coordinators meet directly with the individuals they serve, initially and then on an as needed basis, clients can describe exactly what they need. We acknowledge that families with different backgrounds or styles of living have a wide variety of needs. The flexibility of the FCSP allows each caregiver to get individualized assistance. Coordinators are able to assist caregivers with a one-time change or set up ongoing assistance such as respite care or emergency response services. The program strives to help each client be successful within the structure of their beliefs and culture.

When providing services through the FCSP, coordinators work hard to provide culturally relevant services. In Linn, Benton and Lincoln Counties combined, 354 individuals 60+ report speaking a language other than English and speaking English "not well" or "not at all". This equals less than 1% of our 60+ population.

To better serve individuals with limited English proficiency, SDS produces materials in Spanish. Bilingual staff and translation services are also available when necessary. Our Lincoln County FCSP coordinator regularly outreaches to The Elder's Program of the Confederated Tribes of Siletz. Tribal members are invited to attend all Family Caregiver activities.

Linn and Lincoln Counties are classified as rural counties by the United States Census. Because of this, family caregivers are at higher risk for isolation. The National Institute of Aging reported in 2004 that female family caregivers are 2.5 times more likely than their non-caregiving counterparts to live in poverty and five times more likely to receive Supplemental Security Income (SSI). Outreach to rural senior centers, community bulletins and information spread through the Home Delivered Meals program helps identify isolated caregivers who may benefit from enrolling in the FCSP.

The Linn/Benton FCSP is currently working toward the goal of reaching out to underserved grandparents caring for grandchildren through partnerships with DHS, schools, organized summer programs and local child focused agencies.

As with many of our programs, this program creates change on an individual, community, and state level. The coordinators in combination serve on the State of Oregon Family Caregiver Advisory Board and the State Relative as Parents Advisory Board. Attending quarterly meetings allows coordinators to gather new resources, make new network connections and hear exciting new ideas to utilize in our community program. Our two coordinators are able to consult closely about the direction of the program and share ideas often. Each of these coordinators also meets regularly with managers to review progress, budget, expectations, and community involvement.

The largest limitations to this program in fulfilling its goals are limited budget and low staffing. Along with many SDS programs, coordinators stretch the budget as far as possible by partnering with community agencies and encouraging caregivers to pursue other avenues of support, which can be paired with that of the FCSP.

One gap in service is support for seniors caring for children who are not blood relatives. We have one case involving a grandmother caring for three grandchildren, one blood related and the other two half siblings of the first. To stay within the mandates of the FCSP, she is only allowed to receive assistance for one of her three grandchildren. This also becomes a problem when considering non-traditional families. This poses serious discrimination to the LGBT community.

*Resources for this section include 3, 10 & 26 listed on the reference page.

Goals & Objectives

Issue Area: Family Caregivers					
Goal #1: Increase enrollment and involvement of grandparents raising grandchildren in the FCSP.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Provide additional outreach to seniors raising grandchildren	a. Provide information at the annual Live Well, Age Well Expo every May	FCSP Coordinators	Ongoing		
	b. Network with local organizations specializing in working with at risk children including: DHS, Self-Sufficiency, Child Welfare, Old Mill Center for Children and Families, Local School Districts, CASA, YMCA, The Boys and Girls Club and other afterschool activity programs		Ongoing		
	c. Develop a comprehensive flyer to be printed in English and Spanish and posted on community resource boards		1/13	9/13	
	d. Further educate 2-1-1 and the ADRC call specialists about the program to increase promotion and referral from these services		Ongoing		
2. Establish a grandparents raising grandchildren support group	a. Identify an appropriate venue		1/14	9/14	
	b. Enroll grandparents who are already on FCSP and encourage additional enrollment		Ongoing		
	c. Secure childcare or grandchild support group in a separate room of the same facility		1/14	9/14	
	d. Gather educational information and compile support group topics		Ongoing		

Goal #2: Provide recognition to caregivers.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Continue annual Caregiver Celebration	a. Establish a panel of organizers to contribute to the celebration	FCSP Coordinators	Ongoing		
	b. Research and book educational presentations		Ongoing		
	c. Include relaxation techniques and practices into the celebration		Ongoing		
	d. Continue building relationships with community members to strengthen partnerships		Ongoing		
Goal #3: Increase involvement in the FCSP minority populations and LBGT community.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Outreach to Hispanic population	a. Partner with Centro De Ayuda	FCSP Coordinators	1/13	Ongoing	
	b. Partner with Self Sufficiency and DHS through regional meetings		1/13	Ongoing	
	c. Partner with local churches		1/13	Ongoing	
2. Outreach to the LBGT Community	a. Partner with Friendly House, a SAGE Affiliate in Multnomah County		1/13	Ongoing	
	b. Partner with local churches		1/13	Ongoing	
3. Increase community presentations	a. Research and contact organizations working with our target population to inquire about presenting to staff and clients.		1/13	Ongoing	

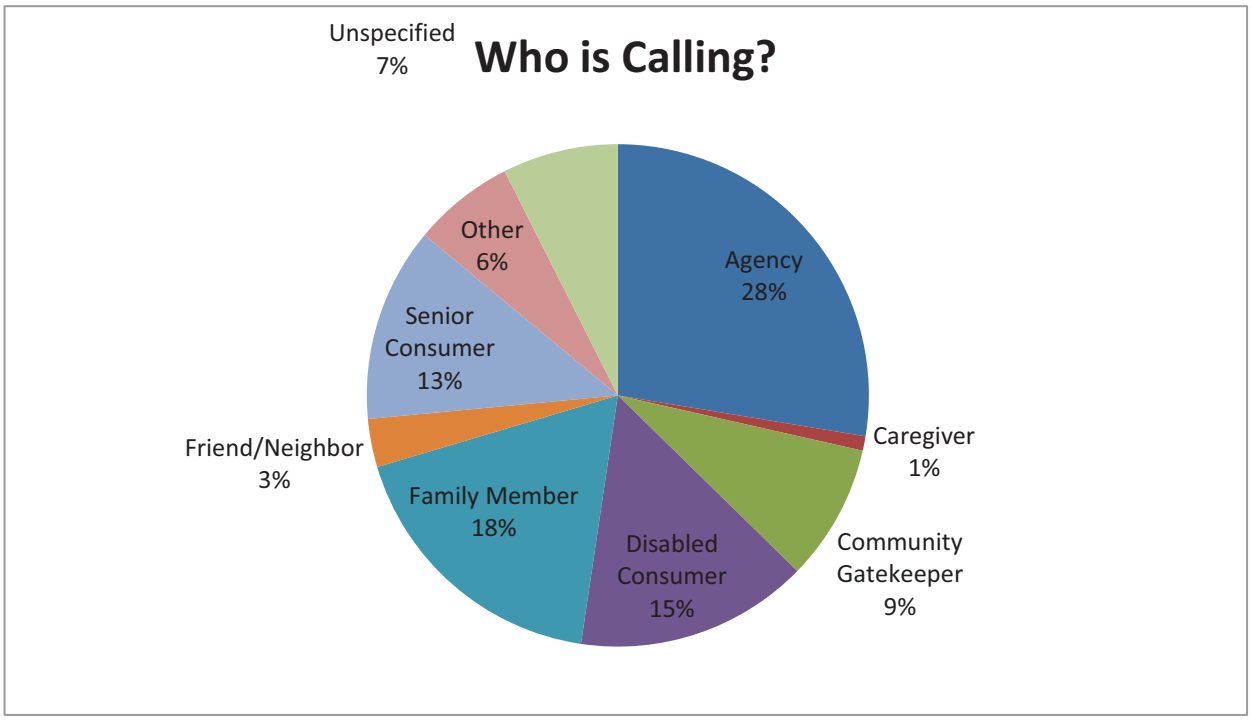
Goal #4: Increase and expand the capacity to offer Powerful Tools for Caregivers Class Series.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Restart Powerful Tools for Caregivers in Lincoln County	a. Outreach to caregivers for enrollment	FCSP Coordinators	Ongoing		
	b. Schedule series dates		Ongoing		
	c. Supply class materials		Ongoing		
	d. Notify caregivers of training dates		Ongoing		
2. Expand Powerful Tools for Caregivers in Linn and Benton Counties	a. Work with local trainers.		Ongoing		
			Ongoing		
	b. Continue providing class materials		Ongoing		
	c. Coordinator will continue the responsibilities of backup trainer		Ongoing		
	d. Provide respite for attendees		Ongoing		
	e. Notify caregivers of training dates		Ongoing		

2. Issue Area: Information and Assistance Services and Aging & Disability Resource Connections (ADRCs)

Profile:

Oregon Cascades West Council of Governments (OCWCOG) is a fully functioning Aging and Disability Resource Connection (ADRC). The ADRC is a service that offers the public a one stop source of information, assistance and Options Counseling regardless of income. ADRC Specialists provide assistance to callers and walk-in clients concerning a wide range of services including: in-home assistance, care facilities, family and caregiver support, peer counseling, transportation, home-delivered meals, personal medication alerts, Medicare counseling, medical equipment, healthy living programs, legal services and more. The ADRC was designed to streamline access to home and community supports and services. Over the past six months (1/1/2012- 6/30/2012), the ADRC received 5,391 calls in total, of which 3,379 were unduplicated individuals. The following table and chart describe who is calling the ADRC line.

Caller	Total	Percent
Agency	1,476	27
Caregiver	50	1
Community gatekeeper	470	9
Disabled consumer	803	15
Family member	965	18
Friend/neighbor	166	3
Senior consumer	670	12
Other	349	6
Unspecified	398	7



Method of Contact	Total	Percent
Email	476	9
Fax	526	10
Mail	53	1
Phone	3,941	73
TTY	0	0
In Person	149	3
Other	15	0
Unspecified	231	4

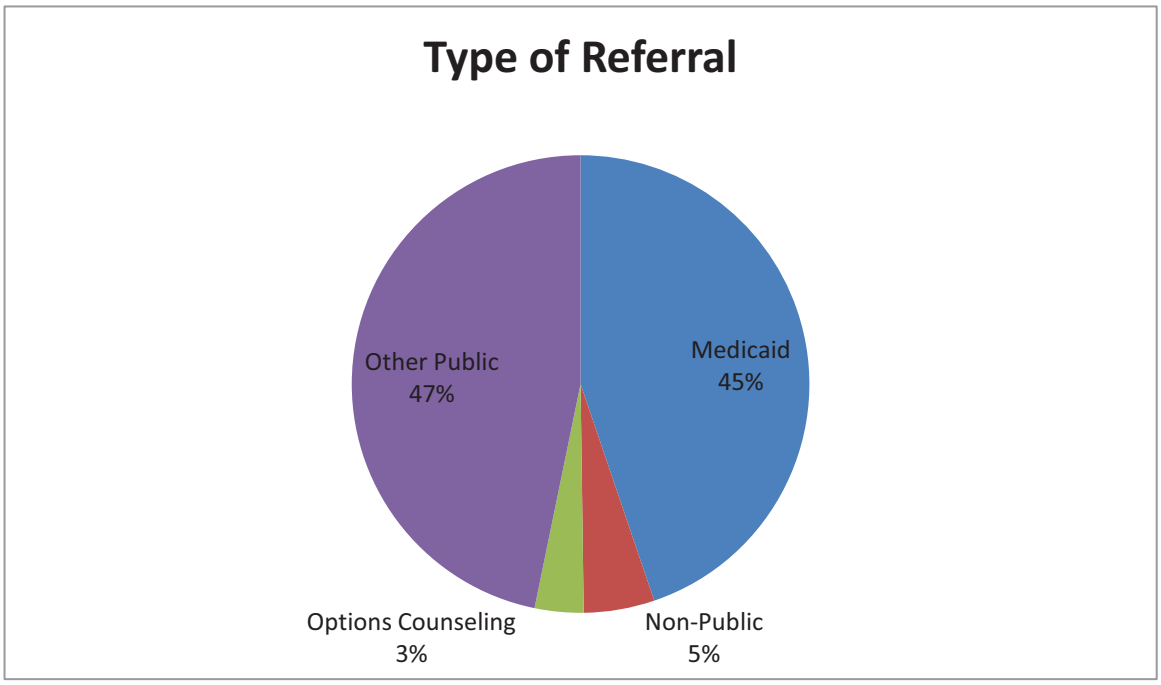
The table above shows how the ADRC has received contact from community members over the past six-month period. The most common method of contacting the ADRC was by phone, followed by fax and email.

The first table on the following page breaks down ADRC contacts by purpose. The majority of contacts with the ADRC are looking for referrals followed closely by information seeking contacts. The second table on the following page breaks down ADRC contacts by referral source. This table provides useful information about which forms of outreach have been most effective and which should be expanded.

Type of Call	Total	Percent
Assistance	102	2
Information	2,085	39
Referral	2,900	54
Information & Assistance	92	2
Information & Referral	172	3
Information, Referral & Assistance	12	0
Referral & Assistance	13	0
Unspecified	15	0

Referral Source	Total	Percent
1-855-OREADRC	4	0
AARP	104	2
ADRC	106	2
Alternative	28	1
Brochure	45	1
Family Member	380	7
Friend/Neighbor	178	3
Gatekeeper	61	1
HCBS/Social Service	279	5
Hospital	289	5
Independent Living	3	0
Internet Website	25	0
Library	0	0
MD/Health	85	2
MDS Section Q	4	0
Newspaper	13	0
Nursing	145	3
Radio	0	0
Rapid Needs	13	0
Self	753	14
Senior Center	15	0
Social Worker	187	3
Television	0	0
Other	155	3
Unspecified	2,519	47

Type of Referral	Total	Percent
Medicaid	1,325	25
Non-Public	148	3
Options Counseling	102	2
Other Public	1,384	26



The table and chart above demonstrate where ADRC Specialists have referred contacts over the past six months. It is important to note that Specialists do not only refer individuals to in-house services, but also to other community agencies. We believe it is crucial that ADRC Specialists are knowledgeable about a wide variety of community resources to best serve contacts. Specialists provide referrals to the service that best suits the needs of the caller.

We currently have ADRC and Options Counseling brochures, posters, business cards and bookmarks available throughout our offices and in key community locations such as senior centers, assisted living facilities and libraries available in English and Spanish. Local newspaper ads have been developed and run consistently throughout Linn, Benton and Lincoln Counties. Public presentations continue to be made by ADRC Specialists, Options Counselors and Case Managers in a variety of community forums educating the public about available resources. Our agency participates in local resource fairs, the Oregon State University (OSU) Gerontology Conference as well a hosts the annual Live Well, Age Well Expo. All contacts, including referral sources, are tracked in the ADRC call module. The call

module database gives us reliable and accessible information on areas needing improvement in marketing our services. In addition, our program has an interagency agreement with the 211info Program operated in Portland. The 211info program refers callers who are looking for resources or services related to older adults or people with disabilities to our ADRC Call Center for expert help and in depth assistance.

ADRC Specialist staff makes up our regional call center, serving Linn, Benton and Lincoln Counties. All new inquiries come through the call center. We have three Alliance of Information and Referral Systems (AIRS) certified Specialists and an additional staff member who will be taking the exam in 2013. As well as assisting the State in the creation of their standards, our local agency has created additional standards the ADRC Specialists follow in an effort to provide consistent information and assistance across our region. The ADRC staff record all contacts in the call module and provide resource information from the resource database. Individuals are then referred to the appropriate program or community resource that fits their unique situation.

Options Counseling is offered in Linn, Benton and Lincoln Counties. Options Counselors are knowledgeable individuals available for face-to-face sessions, either in a community member's home or in one of our offices. These qualified professionals assist clients in determining what care options best fit their specific needs. Together, consumers and Options Counselors weigh the pros and cons of potential options based on the consumer's circumstances, preferences and resources. The consumer can then make an informed decision about long term services and supports meeting their personal goals. The State Unit on Aging (SUA), Portland State University (PSU) and the Area Agency on Aging (AAA) in the ADRC pilot sites developed a set of standards to provide consistent delivery to all consumers.

Our Options Counselors began to use the Care Tool in 2012. The Care Tool is used to document Options Counseling client assessments and action plans. The Care Tool is also used to track all Options Counseling activities for State and Federal reporting.

Options Counselors also play a role in transition support, and have a strong understanding of functional assessments and transition support services. At the initial contact and follow-up as needed, the staff assesses the consumer's need for transition support and provides whatever information and referral is most appropriate.

OCWCOG also has an active Care Transitions Program, Hospital to Home (H2H), in partnership with the local healthcare system IHN CCO and Samaritan Health Services. In our initial pilot as an ADRC, we fostered relationships with local hospital staff in Lebanon, and through a participation agreement and shared processes, piloted a care transitions intervention program (H2H). The program is based on the Eric Coleman, evidence-based model, with a goal to prevent readmission within a 30-day period for the same diagnosis. The initial pilot was started in the Lebanon Hospital (2010) and we will expand to Samaritan Albany General Hospital starting in November, 2012 with grant funding from the Samaritan Social Accountability Foundation and Title IIID funds. Two of our staff (both RN's) have been trained at the Coleman Institute.

We are a pilot site for the statewide toll free ADRC number and the local contact agency for nursing home residents who would like to discuss options available for transitioning back to the community. OCWCOG SDS has an established referral process for private admission assessments (PAA) in all seven nursing facilities due to our ongoing contract with DHS to perform these assessments and assist consumers in their transition from nursing home care. During the pilot (April-December 2012) OCWCOG SDS became a Lead Contact Agency for nursing facility residents who request information and assistance about returning to the community after a nursing facility placement. Initial and ongoing contact was made with seven nursing homes in the tri-county area, and protocols were developed for ADRC referrals in regard to all residents identified through the MDS-Section Q. For private pay consumers identified through both the MDS-Q referrals and established PAA referrals, Options Counselors contact the facility and/or consumer within five working days to assess their needs and start transition support and action planning.

OCWCOG's regional ADRC call center is where all new inquires are routed. Our ADRC Specialists refer all requests for Senior and Disability Services (SDS) managed programs to the appropriate workers. We have standards in place to ensure clients who walk into our office are seen by an ADRC Specialist, case manager or eligibility worker.

As a Type B Transfer AAA, we are the well-known entity that provides public program information, assistance, and access to benefits for seniors and people with disabilities. OCWCOG SDS manages the long-term care services for these populations, and provides the medical and SNAP benefits for consumers served through the county mental health and development disabilities (DD) agencies. Whereas the DD populations are served through a specific Medicaid waiver, our ADRC staff is trained to understand the differences between the waivers and when and if consumers can be served. Our ADRC staff answer all phone calls and see walk-ins for consumers requesting to apply for any and all program benefits. They also screen consumers for all public programs. They review consumer specific information and provide referrals to other agencies (ex: SSA for disability benefits or SSP for TANF) as well as referrals to internal SDS workers who will then determine eligibility. Consumers are given a choice to come into the office, have a home visit or telephone interview when applying for benefits, whatever best fits their needs. ADRC call center staff screen for expedited benefits (ie. SNAP), and ensure a referral is made the same day. Consumers who walk into our office may be seen by a worker and an application completed and eligibility determined the same day. Oregon also has an online application and the URL is provided to consumers if they choose to apply online (CAPI). Applications come to our branches' queue and are assigned to workers the same day they are received. When a worker receives a referral for benefits they make contact with the consumer and assist them with the process. If the consumer is not eligible for any program our agency offers, workers will refer to other community resources and agencies and will maintain contact with the consumer for up to 45 days.

Quality assurance and improvement measures are implemented through review of the call routing system data, the call module data, resource database entries, and ADRC standards developed and improved through monthly review and unit meetings with key staff.

Through the RTZ reporting system, and accurate use of the standards for data entry, we gather call summary data to identify trends in consumer needs (ie. Medicaid, non-publicly funded services, options counseling, other public services), gaps in our local resources, and performance measures for the ADRC staff. All ADRC call data is entered and tracked in the RTZ system. Option Counseling activity, outcomes, and follow-up are entered solely through the Care Tool at this

time, but will be added to Oregon Access for SPR reporting as well. The data collected will include any referrals made for people seeking a return to the community from nursing facilities via the MDS-Section Q referrals, and Options Counseling activities that stem from these referrals.

The Quality Assurance Manager and direct supervisors review key data at the call center level to determine staffing needs, and analyze the information at unit meetings in order to identify trends and areas requiring improvement.

Our agency currently has Memorandums of Understanding (MOU) with Samaritan Health Services, including our Hospital to Home program, 211, Interfaith Volunteer Caregivers (Benton County) and the Senior Companion program. We currently work closely with our sister agencies in Multnomah County, Northwest Senior and Disability Services and LCOG Senior and Disabled Services. Our local ADRC Advisory Council is currently focusing on community education activities such as healthy aging, long term services and supports insurance, Medicare benefits and estate planning. The goal is to partner with a variety of community agencies with similar interests and priorities.

Our agency uses the ADRC call module 100% of the time in order to capture required data. The call module data helps maintain accurate and consistent internal reports, as well as reporting through our Statistical Analysis of Rates and Trends (SART) system.

We have key staff responsible for maintaining our resource database, outreaching to new community agencies and updating existing community information. Our staff has participated in training, onsite testing and given feedback for improvements on the call module, Care Tool and resource database.

Problem/Need Statement:

Currently, there is lack of funding for expansion of ADRC services, which creates an enormous challenge for our agency as we attempt to continue meeting the increasing needs of our communities. During public forums, hosted by OCWCOG, community members voiced their recommendation of recruiting volunteers to increase outreach and visibility. An idea for additional volunteers includes engaging the Oregon State University (OSU) gerontology and pharmacy program students.

The ADRC receives calls from 9:00 to 5:00 with an hour break from 12:00 to 1:00 Monday through Friday. It has been recommended that the ADRC expand its hours to include evenings and weekends. This would allow access to many individuals who work full time and cannot make such calls during the workday. Though real time call answering is preferred, callers can experience wait times due to the growing volume of calls. With increased outreach and marketing efforts, call volume continues to grow in the call center. In order to meet this need along with expanding call center hours, in the future we will need additional funding from State and Federal resources.

Relying on the ADRC is a realistic option when considering the significant increase in the older adult population expected over the next twenty years. The ADRC provides a simple process of engaging community members and getting them the information and resources needed as efficiently as possible. The comfort of speaking directly with a professional over the phone or in person is reassuring to older adults and people with disabilities. This type of outreach needs to be expanded to strengthen long term services and supports planning for the Baby Boomer generation.

*Resources for this section include 11 &13 listed on the reference page.

Goals & Objectives

Issue Area: Information and Assistance Services and Aging and Disability Resource Connections (ADRC)					
Goal #1: Expand information and assistance services to include follow up.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Explore feasibility of expanding call center business hours to include lunch or evening hours	a. Research community preference for service hours expansion	Program Managers	1/13	8/13	
	b. Consult Advisory Councils regarding service hours expansion	Program Managers	1/13	3/13	
Goal #2: Streamline eligibility process for public programs.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Create a process in which consumers are able to apply without an appointment (e.g. call, walk into our office or access online application process)	a. Evaluate the feasibility of creating an intake process within the ADRC structure	Program Manager	10/13	10/14	
	b. Market online application for SNAP and Medical benefits	Program Director	10/13	Ongoing	
	c. Resource assessments to be completed within the ADRC and/or Options Counseling	Information Specialists	1/13	12/13	
	d. Develop a screening and intake process for ADRC staff for walk in clients	Quality Assurance Manager	1/13	Ongoing	
Goal #3: Improve ADRC performance.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Develop a process that allows us to ensure Continuous Quality Improvements	a. Research other ADRCs	Quality Assurance Manager	6/13	Ongoing	
	b. Create requirements and create a measurable data set		6/13	Ongoing	
	c. Consumer involvement by satisfaction surveys and work with Advisory Councils to develop core consumer outcomes	Program Supervisor	6/13	Ongoing	

Goal #4: Increase public awareness and visibility of the ADRC as a reliable community resource.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Develop a marketing plan	a. Utilize the Advisory Council for input	Program Director	1/13	Ongoing	
	b. Include the SUA in the development of the plan		Ongoing		
2. Implement the marketing plan to create an ongoing dialogue with the community	a. Facilitate public meetings and forums	Program Director	1/13	Ongoing	
	b. Develop a series of presentations and presentation schedule	Program Manager	1/13	Ongoing	
	c. Create a set of ongoing professional and partnering relationships in this process	Program Manager & ADRC staff	Ongoing		

3. Issue Area: Elder Rights and Legal Assistance

Profile:

Senior and Disability Services (SDS) recognizes that ensuring the rights of older adults and people with disabilities and preventing abuse, neglect, and exploitation is a large part of the responsibility of an Area Agency on Aging (AAA). Because of the seriousness of these issues, this is one of our priorities. We continue to develop and support programs that focus on public education and the rights of our senior and disabled population.

SDS works with community partners in our effort to increase the public awareness of abuse, neglect and exploitation. One way of accomplishing this is by partnering with the Linn and Benton Counties' Vulnerable Adult Services Team (VAST). Through monthly involvement with this team, SDS continues its work to prevent abuse before it begins. This professional group gives us the opportunity to connect with law enforcement, the legal community, crisis intervention services, mental health, the medical community, hospice and emergency services. These connections benefit the individuals we serve in the form of knowledgeable staff, effective referrals and also strengthens the bond between partners all working toward similar goals.

SDS works collaboratively with agencies such as the Long Term Care State Ombudsman Program, county mental health programs and community crisis services. Training is periodically provided by SDS's Adult Protective Services (APS) team to various community organizations and nursing facilities on protective services and elder rights. Oregon statute requires coordinated reporting with local law enforcement/district attorney offices through the VAST.

Risk Intervention and APS services for older adults and people with disabilities are intended to assess the risk or the potential of harm, as well as investigate and resolve alleged abuse and neglect in our communities. APS is provided to vulnerable older adults and people with disabilities who are at risk as a result of self-abuse or abuse caused by another, neglect or exploitation. In an APS investigation, the investigator interviews the alleged victim, the alleged perpetrator and any other pertinent witnesses. At the conclusion of the investigation, the investigator makes a determination as to whether the allegation is substantiated. In the event of substantiated allegations, the Department of Human Services (DHS), as well as local District Attorneys' offices, may become involved for additional action. Risk intervention, including case management services, are provided for persons who are reported "at risk" and continue to be vulnerable. Risk intervention

activities include continued contact, reassessment, intervention, and the implementation of an individualized plan to reduce the risk of harm.

SDS is committed to the education of our staff as an effective way to address abuse and exploitation. Case Managers and APS staff attend regional and local trainings that speak to the critical issues leading to risk/harm to older adults and people with disabilities, therefore improving their knowledge, skills, and confidence levels while working in the field. One recent topic of presentation was regarding Medicaid fraud.

The utilization of brochures and flyers in English and Spanish allows for outreach to limited English speakers in the region. Educational events are organized to raise the consciousness of the public relating to elder abuse. SDS sponsors events throughout our communities including the Live Well, Age Well Expo, presentations to community partners working directly with vulnerable seniors, and informational trainings to seniors at senior/community centers or congregate living facilities. A major accomplishment of our office is our work to ensure the rights of residents living in facilities by insisting on high quality care and follow up. SDS co-sponsors a Vulnerable Adult Population Symposium to increase community awareness of abuse, neglect and exploitation. The Live Well, Age Well Expo is an annual free community event that attracts over 500 community guests and involves over 150 community partners and volunteers. We ensure that every year presentations and exhibitors provide ample information and education on senior abuse, exploitation, law and safety.

In an effort to prevent financial exploitation, our staff investigates accusations thoroughly. The APS staff often receives referrals through the Aging and Disability Resource Connection (ADRC), family or friends of clients, community partners or case management staff. We have developed relationships with local financial institutions in an effort to make their referral process more efficient and effective. Our staff receives regular training on how to recognize and address financial exploitation.

Oregon Cascades West Council of Governments (OCWCOG) has a contract agreement with our local legal services provider, Legal Aid Services of Oregon. In this contract we support the program with funding that is well beyond the required three percent per year. We have supported these services for more than ten years and we plan to continue this practice. Once per year our Advisory Council conducts a contract review which entails meeting with Legal Aid Services of Oregon in the Albany and Newport offices to discuss goals, objectives, and accomplishments from the previous year. This is a way to continue our already

positive relationship with the agency, as well as ensure accountability for the funding we contribute. This open communication allows for effective referral between our agencies. A significant focus of our partnership with Legal Aid Services of Oregon is to address issues affecting residents living in long term care facilities.

OCWCOG's contract with Legal Aid Services of Oregon calls for a minimum of 400 hours of legal aid services to persons 60 years of age and older in Linn, Benton and Lincoln Counties. Client appointments are scheduled for one day every month at senior centers in Sweet Home, Albany, Lebanon and Corvallis. Appointments are scheduled at the Albany office of Legal Aid Services of Oregon, in client's homes, at nursing homes or telephone appointments as necessary. In Lincoln County, appointments are made at the Newport office of Legal Aid Services of Oregon or at the client's home, if the individual is unable to travel to Newport. A complete copy of this contract has been included as an attachment.

Problem/Needs Statement:

In 2011 Linn, Benton and Lincoln Counties Adult Protective Services (APS) conducted 550 community and facility investigations of potential abuse or neglect of older adults and people with disabilities. The highest incidence of reports is financial exploitation. To address these issues to the best of our abilities, we believe that action needs to be taken comprehensively on every level.

OCWCOG has informal relationships with community and service organizations, but would like to create a formal system of agreements with these organizations and train them to be part of a formal system of support in the community know as the Gatekeeper Program. The Gatekeeper Program is organizations, and their employees, that are from local businesses and they come into contact with older adults on a regular basis as a part of their job. Under the Gatekeeper Program Model, these employees are trained to act as a non-traditional referral source by identifying older adults living in their own homes who appear to have problems that may place them at risk of financial exploitation, health issues that may lead to hospitalization and/or premature out of home placement. These are older adults who have little or no support system to act on their behalf if they experience serious difficulties that compromise their ability to live independently. Examples of Gatekeepers include public utility employees, bank personnel, apartment and mobile home managers, postal carriers, police or sheriff employees, fire departments, paramedics, etc.

Older adults and people with disabilities, frequently living on a fixed income, can often not afford legal aid. To overcome this limitation, more affordable legal assistance is necessary in our region.

During community forums, individuals described how difficult it is to navigate our complicated system while caring for loved ones. First, seniors are not adequately informed about laws regarding gifting money to friends and family members, as it relates to qualifying for State and Federal services. Second, caregivers are not adequately informed of laws regarding how they can and cannot spend a care recipient's money. Insufficient documentation of expenditures can also become a large problem.

Community members agreed that often, seniors and people with disabilities do not like asking for help. Therefore, they sometimes overlook abuse, neglect or exploitation from caregivers to avoid asking others for help.

*Resources for this section include 11, 21 & 24 listed on the reference page.

Goals & Objectives

Issue Area: Elder Rights and Legal Assistance					
Goal #1: Partner with Legal Aid Services of Oregon to develop a stronger system of attorneys working pro bono or at a discounted rate with older adults and people with disabilities.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Research low cost or free of charge services already existing in our region	a. Schedule brainstorm meeting with Legal Aid Services of Oregon	Program Manager	6/13	Ongoing	
	b. Develop action plan to expand available resources		9/13	Ongoing	
Goal #2: Increase public education and awareness regarding older adult abuse, neglect and exploitation.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Develop strategies to outreach to minority and underserved populations	a. Develop alternative formats/language marketing and education materials	Program Supervisor	1/13	Ongoing	
	b. Expand ability to provide presentations in alternative languages	ADRC staff & Options Counselors	1/13	Ongoing	
	c. Incorporate business community and service groups		Ongoing		
	d. Increase public presentations regarding abuse, neglect and exploitation		1/13	Ongoing	

Goal #3: Use Gatekeeper Model to address issues of abuse, neglect and exploitation.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Obtain current Gatekeeper materials	a. Purchase training materials	Program Supervisor	1/13		
2. Train professionals in the Gatekeeper Model	a. Train SDS staff		3/13	Ongoing	
	b. Train community partners		6/13	Ongoing	
3. Train community in the Gatekeeper Model	a. Customize marketing materials		3/13	5/13	
	b. Train presenters		5/13	Ongoing	
	c. Refine presentations		7/13	Ongoing	
	d. Develop community training plan		9/13	10/13	
	e. Host community trainings		11/13	5/14	

4. Issue Area: Health Promotions

Profile:

Oregon Cascades West Council of Governments (OCWCOG) has been involved in a number of activities related to Health Promotion and plans to continue to work in the region with a variety of partners to develop a Coordinated Care Organization (CCO). Our services and partnerships over the last couple of years have helped us create a focus on the goal of assisting older adults and people with disabilities maintain and improve their health.

Over the last two years our agency has worked as a regional coordinator for the Living Well with Chronic Conditions Program and the Tomando Control de su Salud programs. During the project, we worked with the County Health Departments, the Federally Qualified Health Centers (FQHC) staff and the Samaritan Health Services (SHS) Living Well Program. Our role, as it developed during the grant period, was to seek additional funding to expand classes in the community; assist in coordinating those classes and lead trainings; document the services delivered and bring the partners together on a regular basis to evaluate the progress of the work. One of the significant needs in our region was to increase the support in Lincoln County for the delivery of the Living Well with Chronic Conditions classes. With a small amount of funding we were able to support this goal. In addition, we were successful in obtaining grant funds, which targets Lincoln County to offer, for the first time, the Tomando Control de su Salud program for Spanish speakers. A total of three sets of classes are scheduled to take place.

Our region is also very fortunate that the region's largest health care network, SHS, provides a range of health related classes and seminars for the general public. Each quarter the SHS publication offers a new series of classes directed at prevention and early intervention strategies for health conditions as well as offering support groups for a wide range of issues. Several of the cities' parks and recreation departments offer classes, in their Senior Centers or other community facilities (e.g. exercise and balance classes offered at the community pool).

Aging and Disability Resource Connection (ADRC) staff, along with Case Management staff, is very active in the community giving presentations and attending senior oriented events and meetings. We have staff trained in the Powerful Tools for Caregivers class and try to coordinate with the other trained leaders in the community to make this material available to the public.

OCWCOG provides the staffing and support services for the Senior Services Foundation serving Linn, Benton and Lincoln County. The Foundation is the organizer and sponsor of the Live Well, Age Well Expo. The Expo is held each year in Albany and is in its 8th year. The Expo is a health promotion event and offers a range of demonstrations, professional speakers and over 60 booths where local businesses, providers and non-profit organizations offer information and support services for older adults, people with disabilities and their families. The event saw over 500 attendees this year and expects to see an increased attendance in the future.

As a primary support organization for the Healthy Aging Coalition, OCWCOG is very active with community partners and advocates looking at community issues and developing ideas and strategies to educate the public, increase access to information and develop new services. The Coalition has held several public community meetings and is very interested in the partnerships between the public health departments, OSU Extension, OSU aging and public health programs and the hunger security programs in the region. The OSU Center for Healthy Aging Research is a partner in developing projects, writing grants and connecting students as undergraduates as well as graduate level study to help with community projects. These partnerships have demonstrated our regional commitment to work together to promote increased health.

The development of the CCO in the region has also created new ideas and opportunities for innovation. For the last two years, we have worked with the Lebanon Community Hospital to pilot a Hospital to Home Program. This program is a care transitions project that helps support older adults as they transition back home from a hospital stay. Input from community members in attendance at community forums confirmed that this is one of the most difficult transitions for clients and caregivers. It can be an incredibly stressful and confusing time. We are using an evidence-based intervention and have staff trained in the Coleman Model, *Care Transitions Intervention*. We have used this experience to apply for a Center for Medicare and Medicaid Services (CMS) grant for Care Transitions for Medicare members in the region.

The development of the CCO will also begin to create incentives for the health system to develop the medical home model and provide a more seamless care experience for Medicaid members in the region. As a partner in this effort, and in recognition of our expertise with the older adult and disabled populations, we hope to expand our care transitions work and become designated or work with CCO health navigators as a part of our case management role for those on Medicaid.

Hospital to Home

Hospital to Home (H2H) is a *Care Transitions*, demonstration project between OCWCOG Senior and Disability Services (SDS), and Samaritan Health Services (SHS) which started November 1, 2010 at Lebanon Community Hospital**.** In September, 2012, we have a signed participation agreement (MOU) to expand to Samaritan Albany General Hospital.

H2H, Care Transitions Intervention, is an evidence based program that implements the Eric Coleman, MD, *Care Transitions Intervention* model. The program is aimed at improving communication between patients with chronic illnesses and their physicians, with a goal of safe transitions and reduced readmissions to the hospital within a 30-day period. The implementation of evidence based programs aimed at reducing hospital readmissions is a direct result of the Administration on Aging, Health Care Reform and the Aging and Disability Resource Connection (ADRC) grant.

Our participation agreement with Samaritan Health Services reads:

The purpose of this demonstration project is to test the impact that Hospital to Home (H2H) coaches can have on reducing unplanned re-hospitalizations and on individuals' ability to take a more active role in managing their health care.

Five SDS staff RN's from Linn, Benton and Lincoln counties attended the State Unit on Aging training on how to be a transition care, H2H, "coach," in February, 2010. Since that time, we have added a part time RN who was certified through the Coleman Training Program in Colorado, in September, 2011. She is the primary coach at this point in time. Our goal is to send a second staff member to the training in 2013. Our staff actively coach individuals who are discharged from the Lebanon Community Hospital with specific diagnosis: Pneumonia, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Diabetes. The criteria also stipulates that the patients will be Medicare or a combination of Medicare/Medicaid recipients.

At discharge, patients who are identified by the hospital staff as potential program participants are oriented to the program, the coach's role, and time frames and benefits of the program to their overall health management. If patients agree, the hospital refers the individual to our staff.

To date, our coaches have worked with approximately 60 individuals and together with the hospital staff, we are collecting data about additional emergency room visits and readmissions. The program trains coaches to do one home visit and three

follow-up phone calls within a 30 day period (approximately one per week). In addition to the evidence based model, we also assess for any other social service needs and make a referral through the ADRC as needed.

We make every effort (per our agreement) to see individuals in their homes within 48 hours of discharge. At the home visit the coach works with individuals to:

1. Start a current medication list
2. Help to insure they have a follow-up appointment with their physicians (within 3-5 days if possible, as research shows readmissions often happen in the first 4-7 days)
3. Understand if their condition is worsening (by reviewing warning signs and symptoms)
4. Review a personal health record (to set goals for self-management of chronic illnesses, evaluate their support systems, and health literacy)
5. Assess for, and connect individuals with other social services if needed through ADRC referral

The ADRC grant of 2009 and 2012 had very little money for Care Transitions. Most of the funds were earmarked for training. In February, 2011, we secured a grant from the Samaritan Health Services Foundation, Social Accountability Fund, to continue the program and expand to Albany General Hospital. The funding is limited and will be exhausted in December 2012; our goal is to continue using Title III-D funds.

Livable Communities

AARP's 2005 publication, *Livable Communities: An Evaluation Guide*, describes a livable community as, "one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life". We each have our own image of what such a community should look like. For older adults, physical characteristics of a community can greatly impact independence. For instance, older adults need safe pedestrian access around town to grocery stores and other shops, a mix of housing types, accessible health centers and recreational facilities including volunteer opportunities. Poor community design can make it difficult to encourage independence and involvement in the community. For example, busy highways and high walls can divide and isolate communities.

Problem/Needs Statement:

As you will see illustrated by the chart below, the three counties served by this AAA, align similarly to Oregon's statewide statistics for the prevalence of chronic physical conditions and healthy behaviors. The physical activity recommendation is for 30 minutes or more of moderate activity five days per week or 20 minutes or more of vigorous activity three days per week. A healthy weight is a body mass index at or above 18.5 and less than 25.0 kg/m2. The Center for Disease Control and Prevention estimates that national health care spending will increase by 25% over the next 20 years, largely due to medical costs associated with the aging population. It is important to remember that nationally, over 80% of adults 65 years and older are living with at least one chronic condition and 50% have two or more.

Prevalence of Chronic Conditions & Healthy Behaviors

Type	Oregon		Linn, Benton & Lincoln Counties	
Age	60-74	75+	60-74	75+
Arthritis	51%	60%	49%	61%
Heart Disease	10%	14%	9%	12%
Stroke	5%	10%	6%	14%
Diabetes	15%	15%	17%	16%
High Blood Pressure	49%	58%	49%	55%
High Cholesterol	53%	46%	53%	50%
Major Depression	2%	2%	1%	0%
5 servings of fruits & veggies per day	27%	37%	26%	41%
Met Physical Activity Recommendations	55%	46%	56%	44%
Healthy Weight	30%	43%	28%	42%
Current Smoker	13%	5%	13%	5%

In an effort to prevent chronic conditions in our region, OCWCOG focuses on programs such as Living Well with Chronic Conditions and the Tomando Control de Su Salud Program. Tomando Control de Su Salud has not been offered on a regular and consistent basis. We have included increasing the accessibility of this class as a goal for our organization. We also fully support arthritis and diabetes

self-management programs. The large population of seniors and people with disabilities struggling with such conditions need additional opportunities for educational programs and classes.

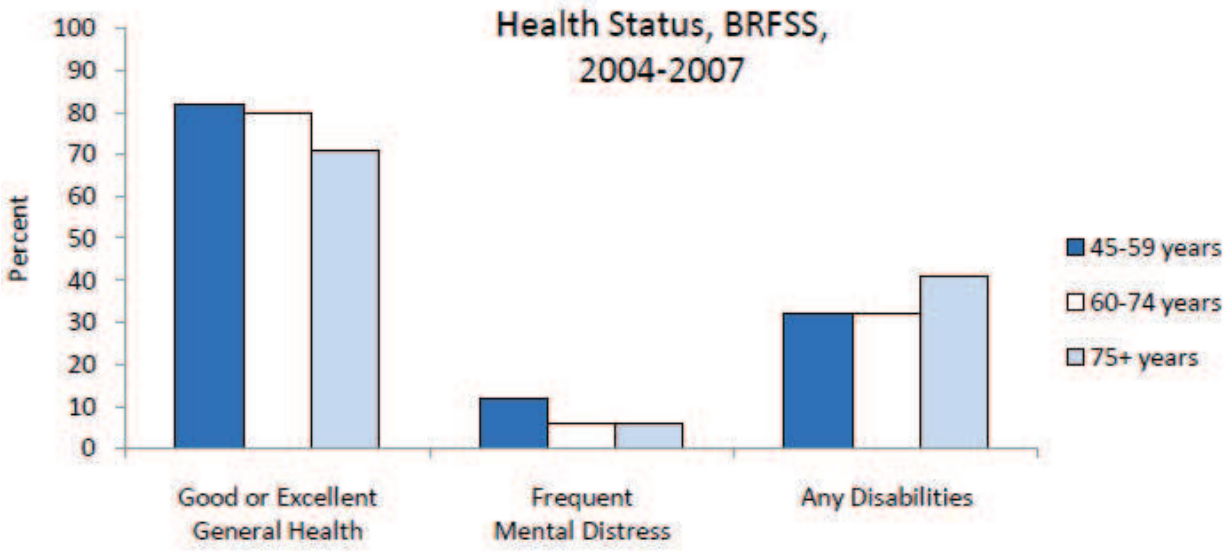
Areas of health not included in the chart above are mental and emotional health. Senior and Disability Services (SDS) realizes that these aspects of health are notoriously given low priority. By engaging professionals in the mental health field in our community needs assessment research, we have been able to incorporate these issues into our strategic goals. Though the chart above shows low percentages of major depression in our region, this and similar conditions are often under diagnosed. One idea is to implement a Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) in our area. PEARLS is an evidence-based in-home treatment program for depression, which integrates a number of behavioral techniques tailored to meet the unique needs of this population.

Transportation is a major component of a livable community. Accessible bus services, curb-to-curb and door-to-door transportation services are all important when considering limitations of our older American population. Transportation was a highlighted need area discussed during public forums and focus groups. Considering the large population of rural seniors and people with disabilities in our region, this is an area our AAA focuses on.

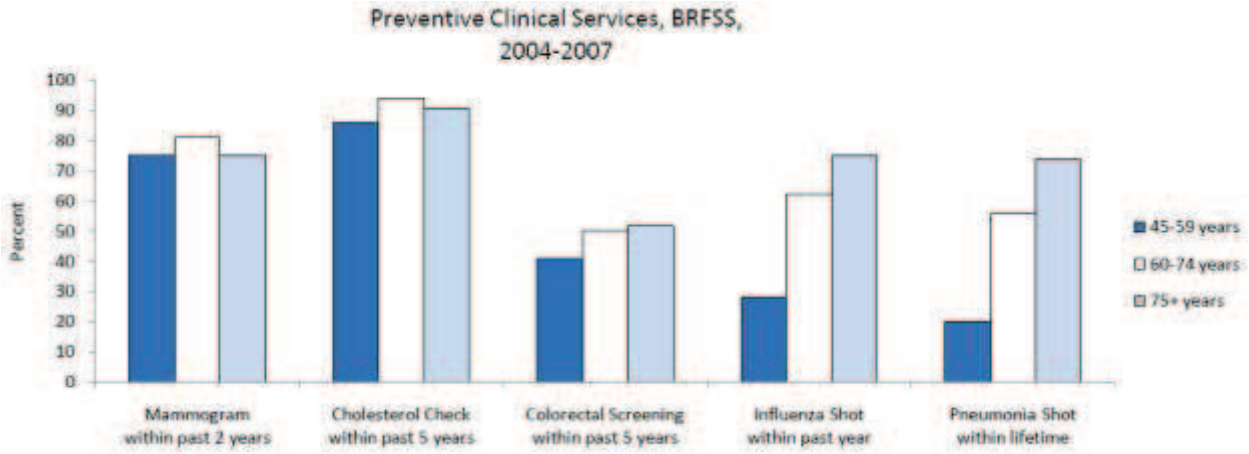
Providing opportunities for social interactions and volunteerism among our senior population will need to be a major focus in coming years. OCWCOG funds and facilitates the Retired and Senior Volunteer Program (RSVP) in Lincoln County. This is American's largest volunteer network for individuals age 55 and over and has a mission to help citizens "reinvent their retirement" through service to the community. The program facilitates a large variety of volunteer and educational opportunities to Lincoln County's senior population.

The graphs on the following page were taken from Oregon Department of Human Services' (DHS) publication, *Healthy Aging in Oregon Communities*, and illustrate key factors in health status and preventive clinical services utilized in our service region.

Linn, Benton and Lincoln Counties



Linn, Benton and Lincoln Counties



*Resources for this section include 1, 12 & 25 listed on the reference page.

Goals & Objectives

Issue Area: Health Promotions					
Goal #1: Expand Healthy Living classes in our region.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Expand chronic disease self-management programs	a. Expand Living Well with Chronic Conditions program	Program Director & Healthy Aging Coalition (HAC)	Ongoing		
	b. Expand and increase Tomando Control de Su Salud program		Ongoing		
	c. Expand diabetes self management classes and education		Ongoing		
	d. Expand arthritis management education		Ongoing		
Goal #2: Improve mental and emotional health of older adults in our region.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Implement PEARLS evidence based program in at least one county in our region	a. Further research the program	Program Director	6/13	12/13	
	b. Train staff in the program		1/14	Ongoing	
	c. Introduce community to the program		7/14	Ongoing	
Goal #3: Strengthen Community Networking Groups.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Strengthen the Healthy Aging Coalition (HAC)	a. Appoint a volunteer or paid coordinator	Program Director	1/14		
2. Form a Healthy Aging Coalition in Lincoln County	a. Strengthen and expand the already existing informal support group	Program Manager	7/14		

5. Issue Area: Native American Elders

Profile:

According to the United States Census, there are 280 Linn, Benton and Lincoln County seniors (65+) who identify themselves as Native American. There are currently two Native American Tribes with elders living in our region, including the Confederated Tribes of Siletz and The Confederated Tribes of Coos, Lower Umpqua and Siuslaw. It is important to note that throughout these statistics, Native American seniors represent adults ages 65+, however, the tribes consider their elders 55+. Therefore, their numbers are slightly higher than what is reported here.

- Total Elders (65+) Tribal Members in Linn Benton and Lincoln Counties: 280
- Total Siletz Tribal Elders (65+) in Linn, Benton and Lincoln Counties: 188
- Total Coos, Lower Umpqua and Siuslaw Tribal Elders (65+) in Linn, Benton and Lincoln Counties: 92

Along with the general American population, Native Americans life spans continue to lengthen and population numbers are expected to increase in coming years. By 2050, the percentage of the older population that is American Indian and Native Alaskan is projected to account for 1.0 percent of the older adult United States population.

The Confederated Tribes of Siletz is comprised of 17 statewide tribal groups with their tribal headquarters in Siletz. There is a governing body – Tribal Council – that is elected from their membership. The Confederated Tribes of Siletz offers many programs and services to their eligible tribal members.

The Confederated Tribes of Siletz's Elders Program is responsible for the administration of Federal and Tribal social services to their eligible Tribal members. The program offers socialization activities, nutrition services, in-home services, caregiver support services, financial benefits and referrals to other local and Tribal resources. To be eligible for the Elders Program, Tribal members must be enrolled and have reached the age of 55.

The Confederated Tribes of Siletz Elders' Program is a Title VI Area Agency on Aging (AAA) serving their tribal Elder population. They receive Older American Act (OAA) funding to administer programs directly through their tribal organization. Their comprehensive AAA Elders' Program offers socialization activities, nutrition services, in-home services, caregiver support services, financial benefits and referrals to other local and tribal resources. As outlined by the OAA,

Oregon Cascades West Council of Governments (OCWCOG) is tasked with outreaching to local tribes and raising awareness of the services we offer, and coordination of services to tribal members.

The Tribe provides medical care of its members in a medical clinic in the Tribal offices located in Siletz, Oregon. A large part of OCWCOG's relationship with the tribe relates to Medicare and Medicaid service billing. The Confederated Tribes of Siletz also provide their own adult protective services to Tribal members in their service area.

The Elders' Programs shares benefit entitlement through the Older American's Act with the programs of the local AAA Senior & Disability Services Office offers. Most OAA Title monies serve seniors 60 years and older, but if they are Native American, they can be served when they reach the age of 55. This is also true of grandparents when served through the FCSP.

Problem/Need Statement:

We would like to educate ourselves further and make sure our employees are as culturally competent as possible. OCWCOG is continually reaching out to the Tribe offering our services, inviting members to be involved in local groups, forums and fairs. It is a priority of SDS to bridge the gap between the two agencies. It is important to continue coordinating and implementing services.

Through Title VI monies, the Tribe is self-sufficient and supports their programs. The local AAA offers the same programs through multiple Title programs such as Title III B-E and Title VII. However, elderly Tribal members often prefer to access their benefits through the Confederated Tribes of Siletz as they are connected through their culture and traditions. Since the Tribe's "restoration", services to tribal members have increased. Services are efficiently developed and managed to specifically address the needs of Tribe members. With a strong family oriented culture that is part of their heritage, it is often unnecessary for Tribal members to go outside of their close-knit Tribal community when needing services.

The State Unit on Aging (SUA) staff, Elder Coordinators and OCWCOG worked together to develop Tribal caregiver guidelines for the Title VI caregiver program and held a full-day training in Warm Springs with other Oregon Title VI programs. This event increased collaboration, communication and coordination between Title III and Title VI Services with the Tribes. Along with this, Siletz Tribal staff was on the Native Caring Committee and sponsored members from the Tribe to attend the Native Caring Conference in March 2011.

OCWCOG works to develop and establish a strong relationship with the Tribe in order to augment all federal benefits/title monies available to entitled members. The goal of the local AAA is to become more involved and participate as much as possible in outreach to the Tribal community. Through awareness and knowledge, it is hoped that the AAA can accomplish this task and get increased Tribal participation in our programs.

*Resources for this section include 11 & 24 listed on the reference page.

Goals & Objectives

Goal #1: Improve our working relationships with the Confederated Tribes of Siletz's for the benefit of our region's senior and disabled population.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Improve Communication and Outreach Services with Tribal Elders	a. Quarterly telephone calls to Tribal leaders	OAA Case Manager	Ongoing		
	b. Invite local Tribal governing members to join OCW Advisory Councils	Program Manager	1/13		
	c. Involve Tribal participation in contributing articles to "Generations" quarterly publications	OAA Case Manager	Ongoing		
	d. Offer to be involved in Tribal outreach programs		Ongoing		
2. Coordinate with local area tribes to provide services for older Native Americans	a. Invite Tribal participation in OCWCOG sponsored events	Program Manager	Ongoing		
	b. Invite Tribal members to be involved in local networking groups; specifically "Senior Services Connect"	OAA Case Manager	Ongoing		
	c. Be involved in Tribal health fairs		Ongoing		
3. Increase awareness and knowledge of programs offered by the local AAA	a. Quarterly articles in quarterly publication of "Generations"	Program Manager	Ongoing		
	b. Direct mailings of flyers & newsletters to Tribal offices	OAA Case Manager	1/13	Ongoing	
	c. Visit Tribal meal sites as appropriate		Ongoing		
	d. Do presentation to Tribal elders		6/13	Ongoing	
	e. Visit Tribal Health Clinic & leave brochures etc.		Ongoing		
4. Participate in Tribal Activities	a. Co-sponsor with Tribe community education forums	OAA Case Manager	1/13	Ongoing	
	b. Have a table at all Tribal health fairs		1/13	Ongoing	

6. Issue Area: Nutrition Services

Profile:

Oregon Cascades West Council of Governments (OCWCOG) Senior and Disability Services (SDS) Senior Meals is composed of congregate noon time meals at each of our dining centers and Meals on Wheels (MOW), home delivered meals. These programs provide seniors, age 60 and over, and people with disabilities, who are Medicaid clients, a hot meal once per day either in a dining room atmosphere or directly in their home. There are 11 meal sites throughout Linn, Benton and Lincoln Counties. Each site has a dining room in addition to MOW delivery routes. This program provides hot, nutritious meals Monday through Friday and frozen meals upon request for weekends and non-serving days.

MOW is more than just a meal: it also serves as a link to the community. Eligible seniors know that they will not only have a nutritious meal, but also a short, friendly visit and safety check by a dedicated trained volunteer driver. Our mission is to ensure that local seniors receive quality, fresh food which helps them to remain independent in their own homes for as long as possible. For many homebound clients, the volunteer driver is the only contact they have each day. Our volunteer drivers have assisted in identifying and avoiding a wide array of emergency situations for homebound individuals. In addition to the regular contacts with the volunteer drivers, Senior Meals Coordinators and Case Managers engage the seniors during an initial assessment to determine eligibility and then again on an annual basis. The initial and annual appointments give an opportunity to determine if additional support services may be appropriate for the client. Case Managers are then able to connect the client with the Aging and Disability Resource Connection (ADRC).

Dining rooms also offer more than just a meal. They provide a social opportunity to meet people and connect with their community. These services, both in the dining rooms and to homebound clients, are vital for many area seniors to receive interaction and a social outlet on a regular basis, in addition to the proper nutrition the food provides. We serve a vulnerable, at-risk population of seniors age 60 and over. Below you will find a list of dining locations throughout our three county area.

Linn County

Albany
Phone: 541-967-7647
Location: Albany Senior Center
489 Water Avenue NW
Serves: Mon through Fri at 11:30 am
Mailing Address:
PO Box 1270
Albany, OR 97321

Lebanon
Phone: 541-451-1139
Location: Lebanon Senior Center
80 Tangent St.
Serves: Mon through Fri at 12:00 pm
Mailing Address:
80 Tangent St.
Lebanon, OR 97355

Mill City
Phone: 503-897-2204
Location: First Presbyterian Church
236 W. Broadway
Serves: Tues & Thurs at 12:00pm
Mailing Address:
PO Box 84
Mill City, OR 97360

South Linn (Brownsville)
Phone: 541-466-5015
Location: Christian Church
117 N Main Street
Serves: Tues & Thurs at 12:00 pm
Mailing Address:
PO Box 658
Brownsville, OR 97327

Sweet Home
Phone: 541-367-8843
Location: Sweet Home Community Center
880 18th St.
Serves: Mon, Tues & Fri at 12:00 pm
Mailing Address:
PO Box 803
Sweet Home, OR 97386

Benton County

Corvallis
Phone: 541-753-1022
Location: Corvallis Senior Center
2601 NW Tyler
Serves: Mon through Fri at 11:50 am
Mailing Address:
2601 NW Tyler
Corvallis, OR 97330

Lincoln County

Lincoln City
Phone: 541-994-7731
Location: Lincoln City Community Center
2150 NE Oar St.
Serves: Mon, Weds & Fri at 12:00 pm
Mailing Address:
2767 SW Beach Ave
Lincoln City, OR 97367

Newport
Phone: 541-574-0669
Location: Newport Senior Activity Center
20 SE 2nd Street
Serves: Mon, Weds & Fri at 12:00 pm
Mailing Address:
20 SE 2nd Street
Newport, OR 97365

Siletz
Phone: 541-444-9169
Location: Tribal Community Center Government Hill
Serves: Mon & Weds at 12:00 pm
Mailing Address:
1227 NE 5th St
Newport, OR 97365

Toledo
Phone: 541-336-2450
Location: Trinity Methodist Church
383 NE Beech St
Serves: Friday at 12:00 pm
Mailing Address:
1227 NE 5th St.
Newport, OR 97365

Waldport
Phone: 541-563-8796
Location: South County Community Center
265 Hemlock
Serves: Mon, Weds & Fri at 12:00 pm
Mailing Address:
PO Box 913
Waldport, OR 97394

The chart below shows the actual number of meals served by county over the last fiscal year. This data shows that Senior Meals serves primarily home delivered meals, rather than congregate. It is difficult to predict Senior Meals trends over the next four years, but reasonable to believe that with the increase in the general senior population, MOW counts will also increase.

County	Total MOW Meals	Total Congregate Meals	Total Meals per County
Benton	16,740	3,465	20,205
Linn	83,998	17,019	101,017
Lincoln	29,378	13,574	42,952
Totals	130,116	34,058	164,174

We are able to offer our clients a choice of two different entrees each day. In addition, we serve vegetables, salads, freshly-baked breads or rolls, fruits, a variety of desserts and milk. Meals are designed to provide individuals with no more than 30 percent calories from fat, averaged over a week's time. Gravies contain zero fat, and tropical oils are not used in the meals. Each meal includes one third of the current Dietary Reference Intakes (DRI), as established by the Food and Nutrition Board of the National Academy of Science National Research Council. All of our menus are approved by a Registered Dietician. Specialty menus for diabetic individuals are available upon request.

There is a suggested donation of $3.50 per meal, although the actual meal cost is more than double that amount. At the close of our fiscal year 2012, average donation for a home delivered meal was $1.01. Average donation for a dining room meal is slightly higher at $1.54 per meal. Some participants are able to donate for their meals and others are not.

The Senior Meals programs would not exist without our dedicated volunteers. Approximately 400 active volunteers participate within our three county area. The value of the hours spent from these volunteers reaches a total of over one million dollars annually. Because people volunteer their time for a wide variety of reasons, it is the responsibility of our meal site managers to find the right job fit for each new volunteer.

In addition to serving meals to seniors, in recent years we found a need to help feed seniors' animal companions. In the past, volunteer drivers often reported that lunches were being shared with pets. To resolve this concern, about five years ago our organization teamed up with the Newport Humane Society to provide dog and cat food to homebound clients upon request. Because this service proved to be incredibly popular, in July of 2010 it was duplicated at our Linn County meal sites when we partnered with SafeHaven Humane Society. Our meal site managers are often told how much this service is appreciated due to homebound seniors being unable to get to the store on a regular basis. Within the coming year, we hope to be able to expand this service to Benton County.

Problem/Need Statement:

As the cost of food and fuel steadily increases, Senior Meals becomes more expensive to operate. It is imperative that we make every effort to provide the highest quality meals to our elderly community members who depend on us. OCWCOG is a partner in an interagency consortium with Lane Council of Governments (LCOG) and Northwest Senior & Disability Services (NWSDS) to procure food service for the meal sites and home delivered meals programs in a seven county area. The food service provider, Bateman Food & Nutrition, operates kitchens in Salem, Newport and Eugene. The food service provider plans the menu, hires, trains and supervises kitchen staff, purchases raw foods and prepares it according to standardized recipes. They are then responsible for delivering the food in our trucks to meal sites, where it is served or packaged for home delivery by our staff and volunteers. They also maintain our kitchen equipment and trucks. A complete copy of OCWCOG's contract with Bateman Food & Nutrition is available in our Albany office.

There are no anticipated major changes in meal production and delivery system. The consortium has had to look for alternative meal service options to decrease costs while continuing to serve as many seniors as possible. Several small changes have been made over the past few years to control costs. Desserts have been eliminated from frozen meals. Baked goods are now switched out for, or served in combination with, fresh or canned fruits as dessert with hot meals. We recently began providing 1% milk cartons rather than 2%. In addition, soup and sandwiches are served one day per week. These small changes have been well received by the majority of our clients.

For many years, monthly nutrition education articles have been provided on the back of each month's menu. These articles are written by the food contractor's dietician and cover a wide variety of topics that relate to seniors and are culturally

appropriate. In addition to these articles, we will begin offering quarterly nutrition education seminars this fall to our dining room participants. The Senior Meals Supervisor will select a topic from a list provided by the State Unit on Aging (SUA) registered dietician. A short presentation will be put together including pertinent talking points. The individual meal site managers will be given the presentation and training at a staff meeting. The meal site managers will then give the presentation to their dining room customers. Any questions which arise that cannot be answered will be compiled and forwarded to the State Dietician. The homebound clients will be presented with similar education once per year on an approved topic by the Senior Meals Coordinator during their initial and then annual reassessments.

The USDA food pyramid states that a healthy person should eat whole grain products, healthy proteins, a variety of fruits and vegetables, eat and drink dairy products and drink lots of fresh water every day. People over 60 have a decreased sense of thirst, which can lead to hydration. Many seniors and people with disabilities do not have access to the healthy foods listed above for financial, transportation, health or other reasons. According to the USDA more than 11% of seniors nationwide face the threat of hunger as they struggle to pay for rent, utilities and medication. The Meals Program offers a very direct solution to this problem.

Undernourished seniors can experience a misdiagnosis of dementia or early Alzheimer's disease, dizzy spells, falls, muscle loss, depression, a weakened immune system and digestive, lung and heart problems.

*Resources for this section include 11, 20 & 24 listed on the reference page.

Goals & Objectives

Issue Area: Nutrition Services					
Goal #1: Ensure that local seniors receive quality, fresh food to help allow them to remain independent and in their own homes for as long as possible.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Provide Meals on Wheels services to homebound seniors who are unable to provide their own nutritious diet	a. Identify all available funding sources to assist in providing services in Linn, Benton and Lincoln Counties	Program Supervisor	Ongoing		
	b. Secure charitable support in the form of grants and fund raising activities to augment limited and declining public resources		Ongoing		
	c. Maintain contracts with local senior centers and churches for convenient service locations		Ongoing		
	d. Maintain a cost effective, quality food service contract		6/13	Ong oing	
	e. Maintain and manage a volunteer program sufficient to operate the MOW program		Ongoing		
	f. Promote the MOW Program to the extent allowed by budget		Ongoing		

Goal #2: Reduce nutritional risk and food insecurity and improve participants' quality of life by providing meals, social interactions and supportive services.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Offer congregate meals in our dining rooms	a. Identify all available funding sources to assist in providing services in Linn, Benton and Lincoln Counties	Program Supervisor	Ongoing		
	b. Secure charitable support in the form of grants and fund raising activities to augment limited and declining public resources		Ongoing		
	c. Maintain contracts with local senior centers and churches for convenient service locations		Ongoing		
	d. Maintain a cost effective, quality food service contract		Ongoing		
	e. Maintain and manage a volunteer program sufficient to operate the program	Program Supervisor & Meal Site Managers	Ongoing		
	f. Promote the Senior Meals dining rooms to the extent allowed by budget		Ongoing		
	g. Operate clean, safe, friendly dining rooms which promote social interaction and mutual support		Ongoing		

Goal #3: Promote increased health through nutrition education.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Offer nutrition information and instruction as required in the Oregon Congregate and Home Delivered Nutrition Program Standards for OAA and OPI	a. Print articles, written by a dietician, on various nutrition topics on the back of monthly menus and post on our website	Program Supervisor	1/13	Ongoing	
	b. Offer participants the nutritional analysis of the menus upon request	Meal Site Managers	Ongoing		
	c. Meal Site Managers will provide a short presentation on a selected nutritional education topic in their dining rooms on a quarterly basis		1/13	Ongoing	
Goal #4: Help to feed our homebound clients' animal companions.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Engage local humane societies	a. Continue partnering with the local humane societies in Linn and Lincoln Counties	Program Supervisor	Ongoing		
	b. Make contact with the humane society in Benton County to attempt to partner with them		Ongoing		
2. Seek out additional funding sources	a. Research grants available		Ongoing		
	b. Apply for any available grants		Ongoing		

7. Issue Area: Retired Senior Volunteer Program

Profile:

The Retired and Senior Volunteer Program (RSVP) originated in Lincoln County in 1972. RSVP is America's largest volunteer network for individuals age 55 and over, with nearly 500,000 volunteers nationally and 382 volunteers locally. The volunteers serve across the country, tackling tough issues in their communities.

RSVP's mission is to help citizens, age 55 and over, "Re-invent their retirement," through service to their community.

Our vision is to be the premier organization for active older adults serving and enriching lives through volunteerism. RSVP encompasses a wide range of volunteer opportunities. Individuals choose how and where they wish to serve. They also choose the amount of time they would like to give. Volunteers choose whether they want to draw on skills they currently have or develop new ones. In short, RSVP helps volunteers find the opportunity that is right for them.

RSVP fills a void in Lincoln County that is not being met by other non-profits or government agencies, by keeping seniors living at home safely and independently. RSVP of Lincoln County's mission is dual. First, RSVP encourages older adults to use their life experiences and skills to answer the call of their neighbors in need. Second, RSVP keeps seniors physically and mentally healthy through the Healthy Living Project, which includes five programs. These programs have been managed productively and consistantly by RSVP and help maintain or improve seniors' health status, support independence, prevent premature institutionalization and allow earlier discharge from hospitals, nursing homes and other residential care facilities.

The following programs are included in RSVP's Healthy Living Project.

1. Grab Bar Program: Gives free and durable medical equipment to help seniors continue to live independently. RSVP responds to requests for durable medical equipment to assist seniors with physical needs and to enhance safety in their homes. Items include grab bars for bathrooms and showers, raised toilet seats and wheelchairs.
2. Trans-Med Program: Helps transport seniors for non-emergency medical appointments. RSVP provides 100-125 rides every month to Lincoln County seniors. That is 1200-1500 rides provided each year.
3. Prescription Assistance: Helps individuals fill out online applications to receive their prescriptions at a free or reduced price.

4. Senior Health Insurance Benefits Assistances (SHIBA): Presents Medicare counseling in an unbiased setting and provides advocacy. Medicare counseling is provided to approximately 75 seniors per month. This counseling helps seniors make informed decisions about Medicare Plans and ensure they receive all of the benefits they are qualified for.
5. The Friendly Visitor Program: This program, with 113 clients, keeps homebound and socially isolated seniors connected to the outside world. The Friendly Visitor Volunteer serves seniors who could be at risk, and have little, if any, contact with others. A Friendly Visitor builds relationships with participating seniors, providing companionship, emotional support, and practical assistance. Visits to participating seniors happen at a mutually agreed upon time and frequency. Support is tailored to individual needs and can be wide ranging: chatting, reading books or mail, going for walks, playing games, and/or telephoning to chat or just check on the senior's well being.

Our goal is to keep seniors living safely and independently in their own homes. RSVP also collaborates with over 80 non-profit and governmental agencies to ensure non-duplicated efforts and that as many needs as possible are being met.

Problem/Need Statement:

Baby Boomers are starting to turn 65 retire at a rate of 10,000 per day. This generation will produce record numbers of people entering retirement. Tom Barlow, online writer for TopRetirement.com, wrote, "Best and Worst States for Retirement." This article noted that Oregon was in the top ten states to retire and RetirementPlacesReport.com stated, "Lincoln County was in the top three places to retire in Oregon." RSVP is looking to the future and preparing for the aging population. The following facts give you an idea of why the five essential components of RSVP's Health Living Project are necessary.

1. Centers for Medicare Services (CMS) reports that 47% of Medicare recipients do not fully understand their Medicare benefits. In Lincoln County, that means nearly 5,000 people may need assistance with their benefit plans.
2. According to The Centers for Disease Control, an older adult will be treated in a hospital emergency department for injuries related to a fall every 17 seconds. Every 30 minutes, an older adult will die from injuries sustained in a fall. Falls are the leading cause of injury among adults in the United States, age 65 years and older. Every hour, one senior adult will die and 183 will be treated in emergency rooms for fall-related injuries.

3. Dr. Becky Briesacher, of the University of Massachusetts Medical School of Pharmacotherapy, a medical journal, and colleagues looked at how well patients comply with filling their prescriptions and dosage instructions. The article stated, "Taking your medications as prescribed is entirely within your control. And it's an easy way to be good to yourself." This advice only works if citizens can afford the prescriptions. As the economy slides downward, more people are finding it harder to purchase their prescriptions. Lack of necessary prescriptions means a less substantial quality of life.
4. A few years ago, a study was conducted by Samaritan North Lincoln Hospital (SNLH), which determined that 1400 - 1600 seniors in Lincoln County do not see their doctor due to lack of transportation.
5. Our society is becoming more and more mobile, with family members sometimes no longer living down the street or even in the same state as their older parents and relatives. This leaves many seniors without social connections in their neighborhoods. An article in USA Today, "Loneliness is Increasing – and It can Harm your Health," declared that loneliness has repercussions on health and well-being.

*Resources for this section include 5, 6, 7, 9 & 23 listed on the reference page.

Goals & Objectives:

Issue Area: Retired Senior Volunteer Program					
Goal #1: Facilitate the opportunity for seniors to serve their community.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Recruit senior volunteers to serve in Lincoln County.	a. Market the program through Generations	Program Supervisor	1/13	Ongoing	
	b. Distribute brochures to increase community awareness of the program		1/13	Ongoing	
	c. Schedule presentations at fairs and facilities		1/13	Ongoing	
	d. Continue to guest on radio shows as a marketing tool		Ongoing		
Goal #2: Aid seniors in making informed decisions.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Help seniors and people with disabilities navigate the Medicare system and have better access to medical benefits.	a. Lay out the options so clients can make informed decisions	Program Supervisor	Ongoing		
	b. Help clients fill out applications for assistance with extra help through Medicare		Ongoing		
	c. Assist clients in accessing medication assistance online		Ongoing		
	d. Present SHIBA workshops biannually throughout the county		1/13	Ongoing	

8. Issue Area: Coordinated Care Organizations

Profile:

In August, 2012, Intercommunity Health Network Coordinated Care Organization (IHN-CCO) signed a contract with the Oregon Health Authority to provide medical benefits to all Oregon Health Plan (OHP) Managed Care beneficiaries in our region.

CCOs are the new model to address the escalating health care costs of an inefficient health care delivery system. The overall medical benefits under the current OHP will not change. The CCO will be operated under a global budget model which makes the CCO responsible for all medical, behavioral health and dental benefits. Dental benefits are scheduled to be included by January, 2014.

The new service delivery model managed by the CCOs is intended to be patient-centered and focused on prevention, early intervention, improved health literacy and chronic disease management. Patient centered primary care medical homes and MDT coordination are key to this new model. A major component of this reform revolves around care coordination. The CCO model requires a higher level of coordination between all levels of the system involved in a member's care and support. Care transitions will be critical in ensuring smooth shifts between levels of care with the goal of preventing readmission to inpatient or more expensive residential care.

Problem/Need Statement:

Our region will be served by Samaritan Health Service's (SHS), IHN-CCO. We have an established signed Memorandum of Understanding that describes how we will coordinate care and services between our agency and the CCO.

The following are critical issues related to the CCO and the Area Agency on Aging (AAA):

- Train staff to ensure seamless transitions for consumers in receiving medical, behavioral health and transition benefits.
- Designate a liaison to help coordinate CCO benefits and the long term services and supports system.
- Work with the CCO to identify high needs members relating to chronic disease, behavioral health, long term services and supports and transportation.
- Develop a comprehensive assessment tool to coordinate with the CCO.

Goals & Objectives:

Issue Area: Coordinated Care Organizations					
Goal #1: Implement the IHN-CCO OCWCOG SDS MOU.					
Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe		Update
			Start Date	End Date	
1. Assist with member engagement and enrollment.	a. Train SDS staff	Program Supervisor	Ongoing		
	b. Create protocol for seamless transitions	QA Manager	Ongoing		
2. Prioritize care coordination.	a. Identify high need members	Program Supervisor	Ongoing		
	b. Coordinate individual care plans with CCO		Ongoing		
	c. Designate an agency liaison	Program Manager	Ongoing		
	d. Implement Hospital to Home in Linn County		Ongoing		

Section D: Area Plan Budget

SEE ATTACHED EXCEL DOCUMENT

Section E: Services and Method of Service Delivery

E-1 Services Provided to OAA and/or Oregon Project Independence (OPI) Clients

SERVICE MATRIX and DELIVERY METHOD

X #1 Personal Care (by agency)

Funding Source: ☐OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Northwest Senior and Disability Services
PO Box 12189
Salem, OR 97309
Subcontractor:
Addus HealthCare, Inc
2401 S Plum Grove Road
Palatine, IL 60067

"for profit"

☐ **#1a Personal Care** (by HCW) Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

X #2 Homemaker (by agency)

Funding Source: ☐OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Northwest Senior and Disability Services
PO Box 12189
Salem, OR 97309
Subcontractor:
Addus HealthCare, Inc
2401 S Plum Grove Road
Palatine, IL 60067
"for profit"

X #2a Homemaker (by HCW) Funding Source: ☐OAA ☒OPI ☐Other Cash Funds

☐ **#3 Chore** (by agency)

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#3a Chore** (by HCW) Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

X #4 Home-Delivered Meal

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):
Subcontractor:
Bateman Food & Nutrition
2655 Hyacinth St NE
Salem, OR 97301
"for profit agency"

X #5 Adult Day Care/Adult Day Health

Funding Source: ☒OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Grace Center
980 NW Spruce Avenue
Corvallis, OR 97330
"for profit agency"

X #6 Case Management

Funding Source: ☐OAA ☒OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #7 Congregate Meal

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):
Subcontractor:
Bateman Food & Nutrition
2655 Hyacinth Street NE
Salem, OR 97301
"for profit agency"

☐ **#8 Nutrition Counseling**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#9 Assisted Transportation**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#10 Transportation**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #11 Legal Assistance

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):

Legal Aide Services of Oregon
433 Fourth Avenue SW
Albany, OR 97321

X #12 Nutrition Education

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #13 Information & Assistance

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #14 Outreach

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #15/15a Information for Caregivers

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #16/16a Caregiver Access Assistance

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #20-2 Advocacy

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☐ #20-3 Program Coordination & Development

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐#30-1 Home Repair/Modification

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #30-4 Respite Care (IIIB/OPI)

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):

Grace Center
980 NW Spruce Avenue
Corvallis, OR 97330

"for profit agency"

X #30-5/30-5a Caregiver Respite

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted X Self-provided

X #30-6/30-6a Caregiver Support Groups

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #30-7/30-7a Caregiver Supplemental Services

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted X Self-provided

☐#40-2 Physical Activity and Falls Prevention

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#40-3 Preventive Screening, Counseling and Referral**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#40-4 Mental Health Screening and Referral**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#40-5 Health & Medical Equipment**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #40-8 Registered Nurse Services

Funding Source: ☒OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Mary Mamer, RN
"for profit vendor"

X #40-9 Medication Management

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):
Provided at annual Living Well Expo in partnership with Samaritan Health Services, Oregon State University Pharmacy students, and Rice's Pharmacy (Corvallis)

☐ **#50-1 Guardianship/Conservatorship**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X **#50-3 Elder Abuse Awareness and Prevention**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☐ **#50-4 Crime Prevention/Home Safety**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#50-5 Long Term Care Ombudsman**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#60-1 Recreation**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#60-3 Reassurance**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#60-4 Volunteer Recruitment**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #60-5 Interpreting/Translation

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Certified Languages International
4724 SW Macadam Ste 100
Portland, OR 97239
"for profit agency"

X #70-2 Options Counseling

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #70-2a/70-2b Caregiver Counseling

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #70-5 Newsletter

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #70-8 Fee-based Case Management

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #70-9/70-9a Caregiver Training

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #70-10 Public Outreach/Education

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #71 Chronic Disease Prevention, Management/Education

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

☐**#72 Cash and Counseling**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐**#73/73a Caregiver Cash and Counseling**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐**#80-1 Senior Center Assistance**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐**#80-4 Financial Assistance**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #80-5 Money Management

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☐ **#90-1 Volunteer Services**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

E-2 Administration of Oregon Project Independence

A. Describe how the agency will ensure timely response to inquiries for service.

The ADRC Resource Specialists in the call center respond "live" to initial inquiries made to the agency about services and resources. The Resource Specialist collects consumer data and provides information about programs that would meet their needs, and the eligibility criteria for such programs.

Oregon Project Independence (OPI) eligibility information includes: Consumers who are not Medicaid-eligible, but meet qualifications for OPI (i.e., are 60 years or older or under 60 years and diagnosed as having Alzheimer's disease and not receiving Medicaid except for Food Stamps, Qualified Medicare Beneficiary or Supplemental Low Income Medicare Beneficiary). If eligible, individuals can receive case management services through OPI. Sliding scale fees are explained at the screening level, but full explanation and calculation are left to the OPI Case Manager. If the consumer believes that OPI is the most appropriate program, their demographic information is entered into the call module and screening is created for Case Manager in Oregon ACCESS (OA).

The Case Manager will make phone contact with the potential consumer and/or family member within 5-10 days, depending on the need of the individual requesting services. An appointment will be made for a home visit to complete a full Client Assessment Planning System (CAPS) assessment and all OPI, State standardized forms.

B. Explain how clients will receive initial and ongoing periodic screening for other community services, including Medicaid.

The ADRC Resource Specialists in the call center screen and assist with all initial inquiries for services, program eligibility and community resources. The specialists will connect callers to all appropriate resources/programs including OPI and narrate any referrals made in the ADRC client data base and OA screening.

During the initial home visit, the OPI Case Manager assesses for OPI eligibility and any other needed resources. Clients receiving OPI services are continually monitored for any changes in their circumstances where they may need other community programs and services. The Case Manager also conducts an annual assessment, but monitors more frequently with phone calls and home visits as warranted based on individual client circumstances. A minimum of three calls are generally made to OPI clients: 1) Monitoring the initial service plan and how

things are going. 2) Within 3-6 months of initial assessment and service planning to monitor and evaluate need for other services. 3) Prior to the annual review to prepare and plan for updates. The agency's OPI Case Manager has a broad-based understanding of Medicaid programs and eligibility, and can confidently assess the client's need when appropriate.

C. Describe how eligibility will be determined.

The CAPS assessment tool is used to determine functional eligibility during a face-to-face, home visit with the client. The assessment is based on information gathered through observation and a client interview, often in collaboration with family members. The OPI Case Manager inputs all required information related to the client's ability to perform Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). The assessment tool then generates a "service priority level" (SPL), which is the basis of program eligibility. Clients with priority levels 1-15 are currently served under OPI in our three counties.

The OPI Income/Fee Determination Record, OPI Risk Assessment Tool, and OPI Service Agreement are also completed at this time. Based on 2011 Legislative direction to establish Statewide consistency for the program, the agency has adopted the use of standardized forms agreed upon by all AAA's.

If the client meets requirements of SPL 1-15, they are determined eligible and they are enrolled in the OPI program, based on the availability of funding. However, the risk assessment weighs the amount of resources, natural supports, and physical function to determine the priority of need, in the event that funding is limited and it becomes necessary to create a wait list.

D. Describe how the services will be provided.

OCWCOG, Northwest Senior & Disability Services (NWSDS) and Lane Council of Governments (LCOG) have a tri-agency (nine-county) In-Home Services Contract with Addus HealthCare Inc. that began July 1, 1999. In our area, the contract serves Linn and Benton counties only. In addition to the contract agency, the Client Employed Provider Program and Homecare Worker registry are discussed, including the benefits and costs of each option. The client decides which option to choose in hiring an in-home care provider, and they often choose to hire home care workers based on continuity and cost effectiveness.

The client plays an active role in determining how many hours per week/month they will need in the areas of personal care, home maker, and chore services to remain independent in their own home. The OPI Case Manager discusses other

community resources and supports that will augment the service hours and develop a comprehensive in-home plan. Once determined, the Case Manager will complete a service plan in OA and process through the appropriate channels (agency or homecare worker) for referral and payment for services.

E. Describe the agency policy for prioritizing OPI service delivery.

Clients enter the system based on many factors. One way is through referrals from partner agencies and our local healthcare system when they have experienced a healthcare crisis or their current supports are no longer adequate. Individuals with the greatest risk factors often enter the system through Adult Protective Services (APS). APS workers refer at-risk clients to the ADRC Call Center and OPI Case Manager to assess for community resources and services that would reduce their risk of being placed in a setting other than home. These cases are often a priority.

All other consumers are assessed on a first come first served basis, however, Case Managers complete a risk assessment on all clients in order to survey them for priority of need at the initial assessment. Funding is used to assist as many high-risk clients as possible.

F. Describe the agency policy for denial, reduction or termination of services.

For new clients or clients that are determined ineligible at review, the Case Manager will have a conversation to inform the client of the reduction, denial or closure prior to sending out any paperwork. The Case Manager will send a written notice to the client, indicating a change in hours, reduction or closure and the reason. The Case Manager also completes the notice or reduction and sends to the home care worker or agency.

The OPI Case Manager will provide the client with information about other available community resources that may meet their ongoing need for help. The client also receives a copy of the agency's formal complaint process and their right to grieve adverse eligibility or service determinations. The Program Manager will be made aware of any denials, reduction or terminations of services prior to the notice(s) being sent, as the complaint process directs clients to the local Program Manager.

G. Describe the agency policy for informing clients of their right to grieve adverse eligibility and/or service determination decisions or consumer complaints.

At initial enrollment, the Case Manager informs the client of the grievance procedure if they feel they have had an adverse eligibility determination made by

the OPI Case Manager, which is found in the agency's Reduction/Closure Grievance Policy if they feel they have had an adverse eligibility determination made by the OPI Case Manager.

OCWCOG brochure about OPI is given to all new applicants, which notifies the consumer of their right to file a complaint and the office contact information.

H. Explain how fees for services will be implemented, billed, collected and utilized.

Cost of service: A calculation of income and medical expenditures are used to determine if a sliding scale fee will be applied for the cost of the OPI service hours assigned. This is discussed with clients at the time of assessment during their initial home visit.

For each client determined appropriate for OPI services, the OPI Case Manager completes an OPI Income/Fee Determination form and the fees are calculated based on the State issued fee schedule. If housekeeping or personal care services are provided through the agency contractor, the Case Manager sends a copy of the client service plan to Addus Healthcare to begin service and to inform them of the percentage to be billed to client.

A written approval is sent to the client, confirming the proportion of service cost which the client is to pay and the estimated monthly cost. The agency contractor sends out client billing letters and collects fees in accordance with the requirements of the agency contract.

Consumers receiving home care worker services and paying a portion of OPI service costs are billed by OCWCOG staff who enter the fee percentage(s) into the OA billing system. In addition, an annual $5 minimum fee will be applied to all individuals receiving OPI services who have adjusted income levels at, or below, the Federal Poverty Level and have no fee for OPI services. All fees collected are submitted to OCWCOG on a monthly basis and are applied to the overall budget and billing of OPI services submitted to the State.

When an OPI case is opened, the client is sent the Service Agreement form confirming the start of the OPI service and notifying them of their fee for service. The OPI Income/Fee Determination form is reviewed and updated annually at the service assessment review date.

I. Describe the agency policy for addressing client non-payment of fees, including when exceptions will be made for repayment and when fees will be waived.

Through the OA reporting and billing system, clients are billed monthly and one time per year for the annual fee when applicable. Administrative support staff notifies the Case Manager if fees are delinquent; the contract agency does the same. If non-payment occurs, the Case Manager contacts the client and discusses the reasons for non-payment and evaluates the hardship and/or reason, reminding them they must pay the fee within 10 days or risk closure.

Fees are mandatory and required, no matter how small. However, a Case Manager might request a fee be waived in a situation of undue financial hardship or an Adult Protective Service involvement. This would be rare and circumstances would be extenuating. The Program Manager would be consulted in each case where a waived payment is requested.

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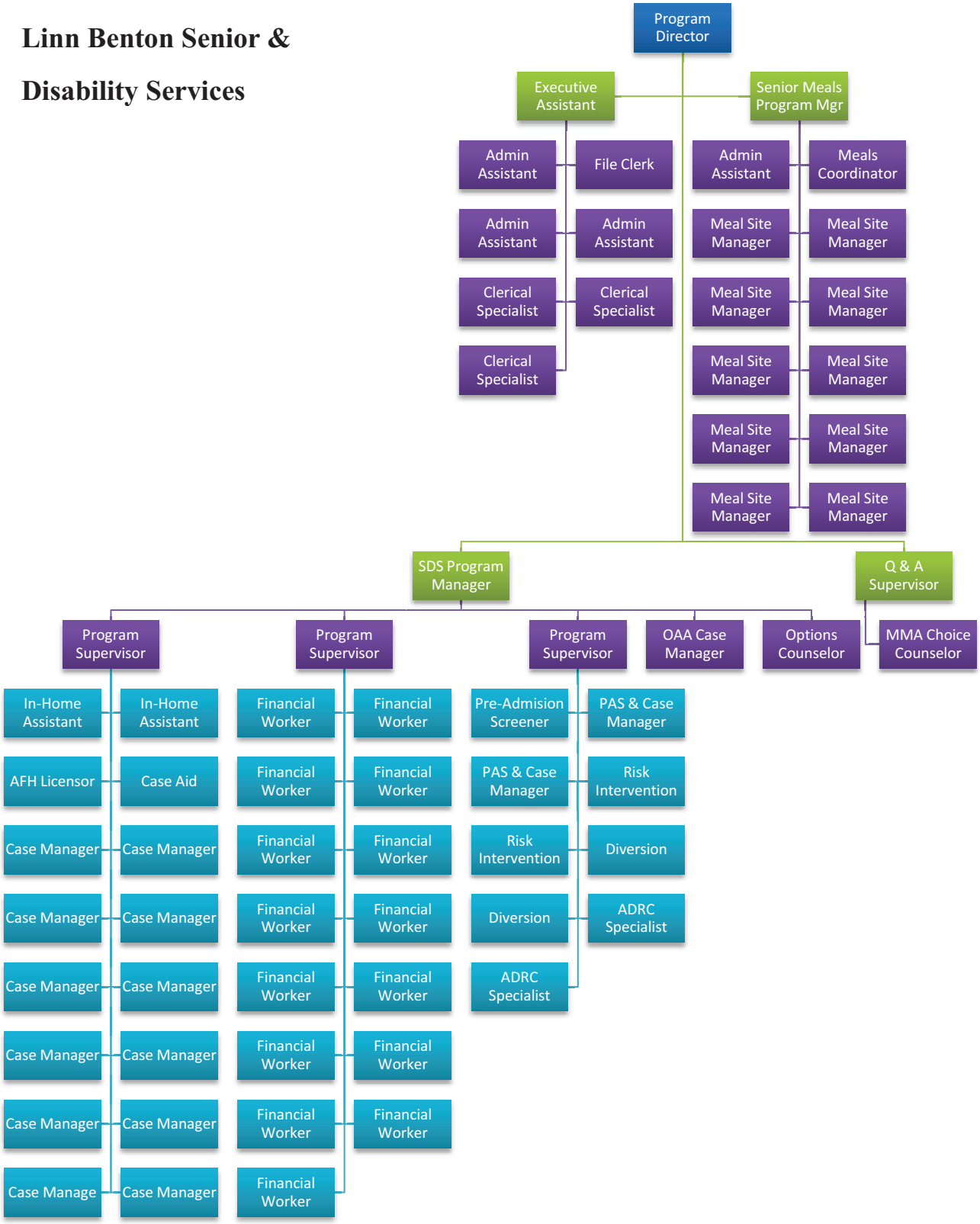
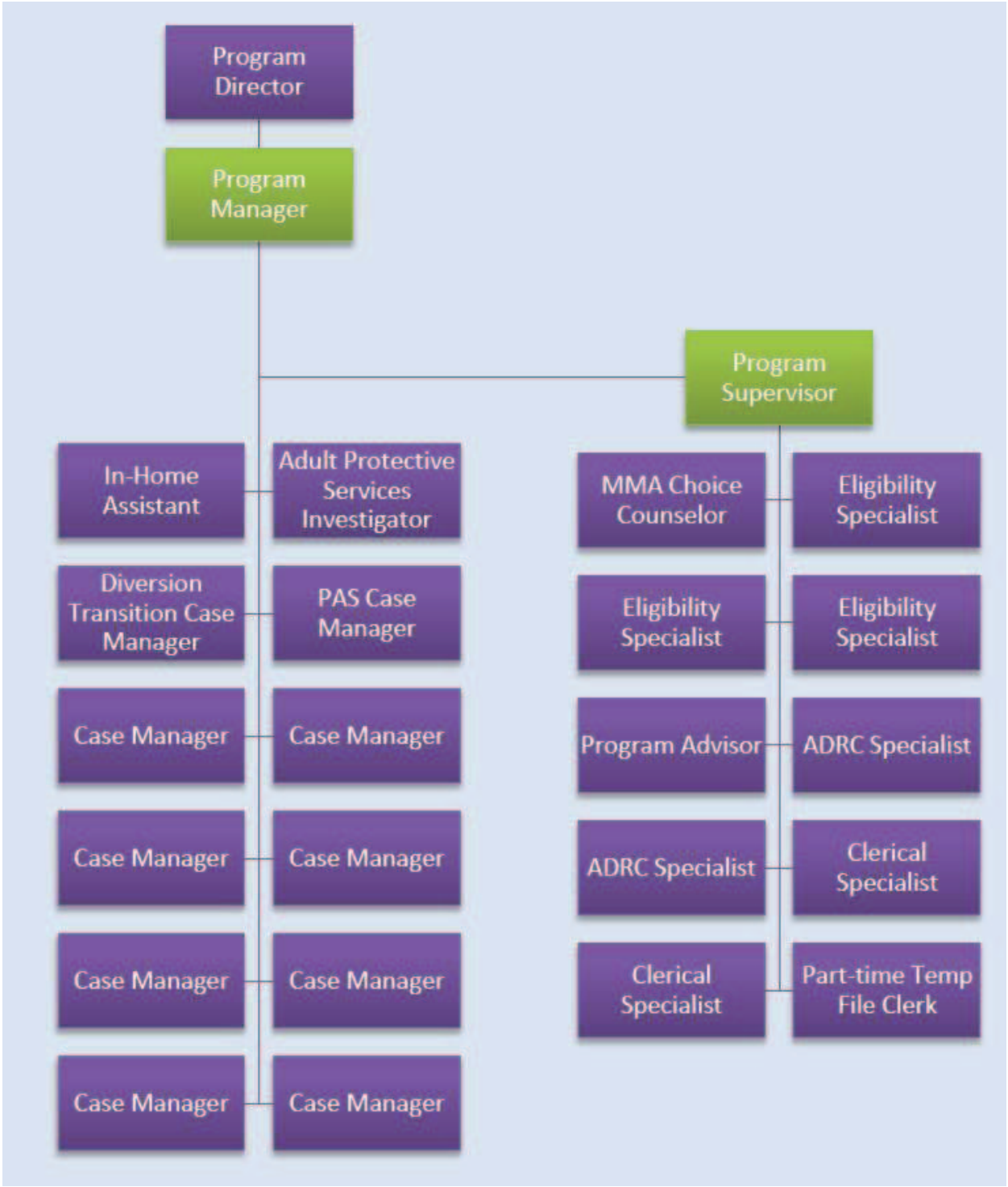
Appendices

Appendix A Organizational Chart

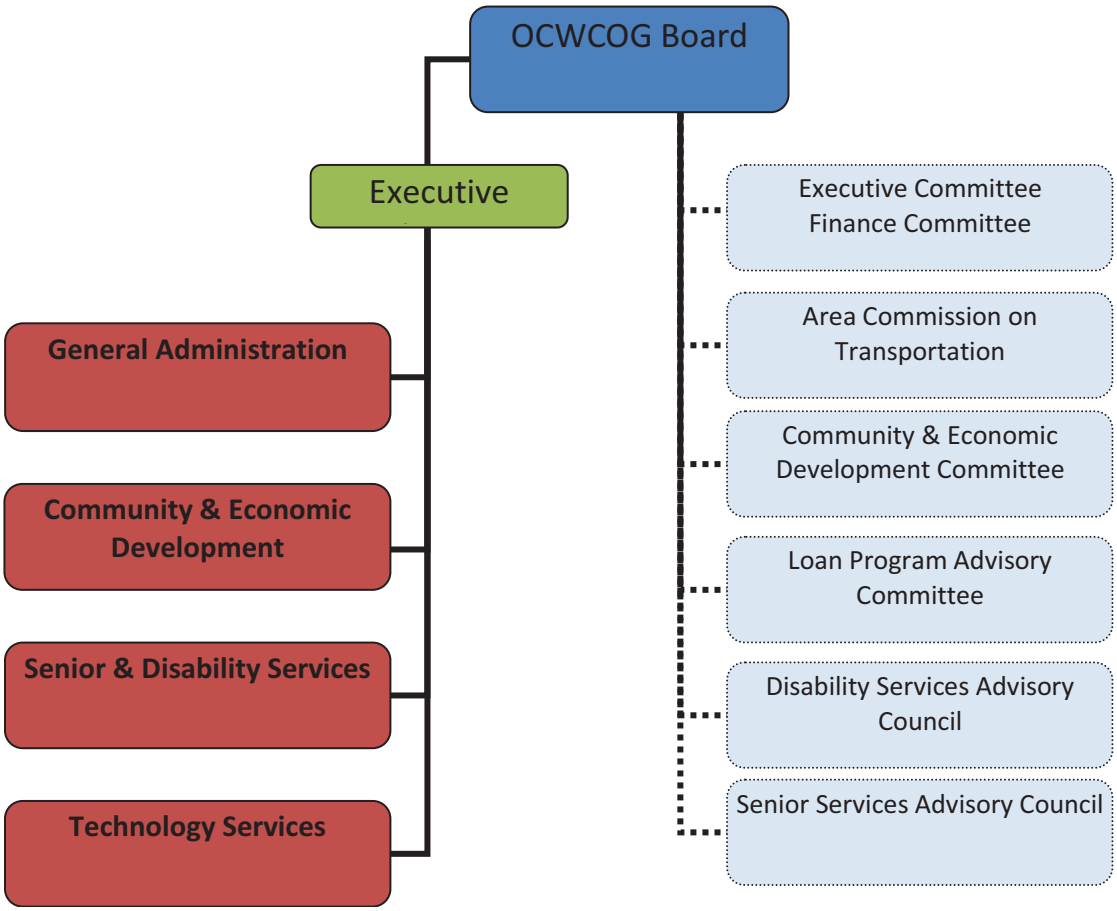
Linn Benton Senior & Disability Services



Lincoln Senior & Disability Services



OCWCOG Board



Appendix B Advisory Councils and Governing Body

Council of Governments Board Members, July 2012

Name and Contact Information	Representing	Date of Term Expiration
Jay Dixon, Commissioner	Benton County	12/31/12
Bill Currier, Mayor	Adair Village	12/31/12
Julie Manning, Mayor	Corvallis	12/31/12
Dave Ballard, City Council	Monroe	12/31/12
Ken Schaudt, Mayor	Philomath	12/31/12
John Lindsey, Commissioner	Linn County	12/31/14
Sharon Konopa, Mayor	Albany	12/31/12
Rob Boyanvosky, City Council	Brownsville	1/1/14
Wade Doerfler, City Council	Halsey	12/31/12
Robert Duncan, Mayor	Harrisburg	1/1/14
Ken Toombs, Mayor	Lebanon	12/31/12
Lisa Metz-Dittmer, City Council	Millersburg	12/31/12
John Nuber, City Council	Scio	1/1/15
Craig Fenitman, Mayor	Sweet Home	12/31/14
Seaton McLennan, Mayor	Tangent	12/31/14
Bill Hall, Commissioner	Lincoln County	1/7/13
Pam Barlow-Lind, Siletz Tribe	Confederated Tribe of Siletz	2/2013
Carol Conners, Mayor	Depoe Bay	2/2013
Chester Noreikis, City Council	Lincoln City	12/31/12
Dean Sawyer, City Council	Newport	12/31/12
Maureen Keeler, Special Projects Manager	Port of Newport	None
Leslie Button, Mayor	Siletz	12/31/12
Monica Lyons, City Council	Toledo	12/31/14
Dann Cutter, City Council	Waldport	12/31/14
Ron Brean, Mayor	Yachats	12/31/12

Senior Services Advisory Council Membership, July 2012

Name and Contact Information	Representing	Date of Term Expiration
Mike Volpe (DSAC Liaison – Designated)	DSAC	None
Bill Hall (Lincoln County Commissioner – Designated)	Lincoln County	None
Suzette Boydston (Senior Companion Program)	Benton, Lincoln, Linn County	None
Deborah Adams	Benton County	7/2012
Anne Brett	Benton County	7/2012
John Dilworth	Benton County	7/2012
Mark McNabb	Benton County	7/2013
Mary Lou Boice	Lincoln County	7/2013
Bill Turner	Lincoln County	7/2013
Lolly Gibbs	Linn County	7/2013
Patricia Marion	Linn County	7/2012
Jerry Sheridan	Linn County	7/2013
Catherine Skiens	Linn County	7/2012
Tim McQueary	Linn County	7/2013

Total number age 60 or over = 10

Total number minority = 0

Total number rural = 4

Total number self-indicating having a disability = 4

Disability Services Advisory Council Membership, July 2012

Name and Contact Information	Representing	Date of Term Expiration
Mike Volpe	Benton County	June 2013
Christine Harrison	Linn County	June 2013
Terry Brown	Linn County	June 2013
Rusty Burton	Linn County	June 2013
Lisa Bennett	Linn County	June 2013
Larry Murphy	Lincoln County	June 2013
Patty Murphy	Lincoln County	June 2013
Bill Hall, Commissioner	Lincoln County	Designated

Total number age 60 or over = 2

Total number minority = 0

Total number rural = 4

Total number self-indicating having a disability = 5

Appendix C Public Process

2012 SDS Community Forums

As part of the public process during the development of this Area Plan, SDS hosted three community forums, one in each county we serve. After presenting information about the organization and services we provide to community members, forum attendees were able to discuss need areas, need levels, solutions and goals. Community members were invited to these forums through email invitations, community bulletin board flyers, radio advertising and newspaper advertising in each community. The first forum was held on Thursday, June 14th, 2012, at Chintimini Senior Center located in Corvallis, Oregon, from 5:00-6:30pm. There were 11 individuals in attendance along with OCWCOG's Program Support Supervisor, Project Specialist, and Program Supervisor. The second forum was held on Monday, June 18th, 2012 at the Albany Senior Center in Albany, Oregon from 5:00-6:30pm. There were 10 individuals in attendance along with OCWCOG's Program Support Supervisor, Project Specialist and Program Manager. The third and final forum was held on Wednesday, June 20th, 2012 at the Newport Senior Center in Newport, Oregon from 5:00-6:30pm. There were 5 individuals in attendance along with OCWCOG's Program Support Supervisor, Project Specialist and Program Manager. Below you will find a list of discussion questions covered at these meetings. Participants also received an agenda and verbal overview of the Area Plan process including goals.

Discussion Questions

1. What do you believe are the hardest aspects of aging and/or having a disability?
2. What are the hardest aspects of care giving?
3. How can Senior & Disability Services help aid with the difficulties associated with aging, having a disability, and care giving?
4. What services do you feel Senior & Disability Services currently provide best?
5. What improvements would you like to see in our current system?
6. Specific topic areas of interest?
7. What do you believe are the most incredible aspects of aging?

Beginning on page 112 you will see detailed responses from each forum. This information has been included to detail the specific concerns from each county. However, immediately below there is a summary of the consistent concerns expressed throughout the region served by OCWCOG, and a list of participant suggestions.

* Where questions have been skipped, it indicates that there was not time to discuss that particular question or no attendee chose to contribute.

Results Summary

In each of the three counties, attendees felt the most important challenges of growing older or living with a disability are: physical limitations, emotional changes, including feelings of powerlessness and sadness, and limited transportation. Attendees expressed the difficulty that they experience when asking for help and where to go to get answers. Participants expressed issues related to: inadequate finances, lack of health insurance, understanding technology, and finding quality caregivers.

When asked about the difficulties of care giving, community forum attendees brought up numerous key concerns. They spoke about how care giving responsibility often falls to one person. Caregivers often face challenges of balancing work and family and caregiver responsibilities which can lead to feeling emotionally and physically overwhelmed. Caregivers often struggle with self-care, which can have a negative impact on the quality of care they are able to provide to their loved one. Participants identified the following as being particularly difficult: providing financial support, paying bills, navigating and understanding complicated service systems, and managing medications. Also identified were issues about care transitions associated with hospital admissions, discharges and transitioning back home.

Attendees offered many suggestions as to how the issues mentioned could be addressed. The one major idea raised was that SDS could be more visible in the community, including increased outreach. Attendees agree that the ADRC is useful, but additional outreach in the community would help.

Seniors want face-to-face interactions and personal connections. Changes in the service delivery system are forcing clients to rely more on technology, which is not as personal and comfortable for older adults. Attendees also commented about ADRC call center wait times and the desire to have calls returned more quickly. The forum attendees suggested there is a need for: additional support groups, trainings for caregivers, and the increased availability of respite care. There was a consistent theme for improved program flexibility to serve individuals and their unique circumstances, especially where transportation was concerned. Many SDS programs and program standards feel rigid and rushed.

During the forums, SDS received praise for the Options Counseling, Meals on Wheels, and Adult Protective Service programs. Attendees also complimented how well SDS assists low-income individuals in our community.

As a way of closing each forum, attendees were asked to identify the most incredible aspect of aging. The most popular response was that individuals get to choose more freely how they spend their time. Attendees expressed a great appreciation of their new sense of priorities, which they attribute to having a broader perspective. Attendees also commented that they enjoy sharing experiences with the younger generations as well as socializing with their peers.

Original ideas derived from Forum Results

1. Organize a communal living system. Develop a roommate compatibility search for seniors who want to live in homes with other seniors, but not in living facilities. This would allow for pooling resources and improved social support and interactions.
2. Connect students with seniors.
3. Senior & Disability Services needs a prominent sign on the OCWCOG building.
4. Community members often cannot locate the building because of limited signage.
5. Develop a prescription pick up service. Many seniors are driving when they should not because they need to pick up prescriptions.
6. Improve Meals on Wheels food taste and quality. Consider a local food vendor who can provide fresh and healthier products.
7. Develop more preventative programs, rather than focusing on crisis.
8. Work with the housing authority to improve Section 8 housing standards for seniors; possibly recruit volunteers to do maintenance and upkeep on Section 8 senior living facilities.

Corvallis Forum, Thursday, June 14, 2012

1. What do you believe are the hardest aspects of aging and/or having a disability?

- Physical limitations, loss of independence and ability
- Medical/medication issues
- Emotional changes, maintaining self esteem, grief, sadness
- Death of loved ones and loss of social network
- Transportation
- Accessibility and equipment design, wheelchairs, sidewalks, doorways
- Having to leave my home
- Cutting back services
- Finding quality caregivers, theft
- Relying on advocates
- Community changes, not understanding technology
- Don't know where to go for help and do not want to admit to needing it

2. What are the hardest aspects of care giving?

- Busy schedules, too much work for one person
- Organization of medications, insurance, and bills
- Endless patience
- Maintaining dignity and independence of a loved one
- Emotional aspects, career vs. family care giving, watching a loved one in pain, exhausting, challenging, overwhelming
- Physical aspects, many care givers are also over 60
- Difficulty navigating system
- Respecting self determination
- Financial responsibility of family care giving

3. How can Senior & Disability Services help aid with the difficulties associated with aging, having a disability, and care giving?

- Transportation, more flexibility on times, drivers are so rushed they tend to make mistakes, better scheduling, what to do in an emergency situation (van breaks down), need more options
- Be available in a more comfortable setting
- Remember people's abilities, not label them by their disabilities
- Do not use labeling language
- Improve flexibility of programs, OPI can easily cater to individual needs more than other programs
- Increase funding and training for support groups-ideas include Parkinson's,

dementia, low vision
- Create relationships with community churches and community partners to increase visibility

4. What services do you feel Senior & Disability Services currently provide best?

- Options counseling, wonderful program, well run and caters to seniors needs
- Help to low income individuals

5. What improvements would you like to see in our current system?

- More consistent Case Managers
- More efficient call back time
- Not wait on hold for so long when calling the ADRC
- Assessment questions are too redundant
- People who do not meet service levels are falling through the cracks
- Put more emphasis and money into prevention, rather than waiting for crisis
- Simplify documents
- Less technology, more face to face interactions
- More outreach, you cannot have the ADRC receiving calls without someone in the community actively finding seniors who need help
- Improve website, not enough information

7. What do you believe are the most incredible aspects of aging?

- Freedom to do what I want, ability to volunteer
- Can focus on self
- Less meetings
- Travel
- Can say "No."

Albany Forum, Monday, June 18, 2012

1. What do you believe are the hardest aspects of aging and/or having a disability?

- Physical limitations, loss of independence
- Medical problems
- Emotional changes, feeling powerless, isolated, lack of social interactions
- Community changes
- Technology changes, young generations in charge running things how they would understand, but not how seniors would understand
- Asking for Help
- Relying on others

- Transportation
- Financial, living on a fixed income
- Lack of support/resources, complicated systems, restrictions too rigid
- Finding qualified caregivers

2. What are the hardest aspects of care giving?

- Self care
- Overwhelming, considering jobs, family, and other responsibilities
- Medication management, fear of overdose, confusing transfers from hospital to nursing home to home
- Navigating services
- Service guidelines too strict, programs not flexible
- Emotional, isolation, watching a loved one in pain

3. How can Senior & Disability Services help aid with the difficulties associated with aging, having a disability, and care giving?

- Transportation! Too expensive in rural areas
- Outreach, people do not know about services, newspapers may be helpful for advertisement
- Respite for caregivers to attend support groups
- More APS, investigate families who take advantage of their seniors
- Training for monitoring medications

4. What services do you feel Senior & Disability Services currently provide best?

- Meals on Wheels, provides food and companionship/social interaction
- Adult Protective Services

5. What improvements would you like to see in our current system?

- ADRC vs. Outreach, seniors need face to face interaction, personal connection
- Visibility! Get a sign on your building and advertise
- Out of town transportation options, often needed to see a specialist
- Too many restriction on services, improve flexibility
- Improve Meals on Wheels food taste and quality, consider a local food vendor
- Offer volunteer/care giver trainings
- Provide a prescription pick up service, many seniors are driving when they should not because they need to pick up prescriptions

- We need help navigating the system and filling out applications, OSU students in social services might volunteer to help

6. Specific topic areas of interest?

- Need more outreach and visibility, utilize volunteers for this
- Work with the housing authority to improve Section 8 housing standards for seniors, possibly recruit volunteers to do maintenance and upkeep on Section 8 senior living facilities

7. What do you believe are the most incredible aspects of aging?

- Freedom to do what we want, when we want, including volunteering
- Ability to enjoy kids and grandkids
- Retirement, if you can afford it
- Larger, grander perspective
- Different sense of priorities
- Socializing

Newport Forum, Wednesday, June 20, 2012

1. What do you believe are the hardest aspects of aging and/or having a disability?

- Physical limitations
- Emotional changes-depression and limited social support, friends and family dying
- Not knowing where to go for help
- Financial Stability, living in poverty, never able to retire, outrageous cost of living facilities
- Transportation, problems with dial a ride
- Limited health insurance

2. What are the hardest aspects of care giving?

- Not knowing where to go for help, get the ADRC word to schools and counselors, there are many school aged grandchildren caring for grandparents
- Not understanding the rules and regulations, specifically rules on how money can be spent
- Emotional, feeling unappreciated, guilt, obligated
- Watching loved one in pain
- Financial responsibility, keeping track of spending

3. How can Senior & Disability Services help aid with the difficulties associated with aging, having a disability, and care giving?

- Provide caregiver training
- Provide respite care and friendly visitors
- Facilitate and fund additional support groups
- Organize communal living system, roommate compatibility search for seniors who want to live in homes with other seniors, but not in living facilities. This would allow for pooling resources and improved social support and interactions.
- Connect students with seniors

5. What improvements would you like to see in our current system?

- Visibility and Outreach, ideas include presentations to schools, senior centers, living facilities and posting flyers for ADRC and APS
- Improved call back time and rate
- Less time on hold for the ADRC

7. What do you believe are the most incredible aspects of aging?

- Senior Discounts
- Sharing experiences and stories with children and grandchildren
- Being able to choose how to spend my time
- New priorities

Healthy Aging Coalition (HAC) Community Forums

The Healthy Aging Coalition sponsored two community forums that brought community members and professionals together to discuss issues related to seniors and access to Supplemental Nutrition Assistance Program (SNAP). The first forum was held on May 22nd, 2012 at Good Samaritan Episcopal Church in Corvallis, Oregon from 5:00-6:30pm. The second forum was held on May 23rd, 2012 at the Albany Public Library in Albany, Oregon from 5:00-6:30pm.

Themes/Outcomes from the Senior and SNAP Forums

- Train volunteers to perform more outreach/education
- Brochures and flyers provided at agencies, medical offices, food pantries, libraries
- Public transportation provide more "market bus" transport
- Network with faith based organizations, assisted living facilities and neighborhoods to organize ride shares and food deliveries

Record of Group Questions

** Indicates what each group voted as most important

Media Questions:

1. How can media be used to help with seniors' perceptions and understanding of SNAP?
2. What types of messages should be portrayed in the media?

Corvallis

** Trainings for Food pantry volunteers, caregivers and senior service agencies

** Libraries host public informational meetings

- Flyers posted around town, doctor's offices, rural towns and on Dial-A-Ride
- TV local channels (OPB), Newsletters
- Train volunteers to give "30 second elevator speeches"

Albany

** Advocate for transportation issues to mayor and city council, local congress, get political interest

** Grassroots organizing, word of mouth outreach, SNAP and farmers' market double SNAP

- Write letters to the editor
- Brochures to residents, Information to buildings, visit apartments like Riverview Place
- Computer generated information
- Senior SNAP advocate, similar to veteran advocate, navigate the eligibility paperwork, give personal help that may be needed
- Share stories of seniors who use and benefit from SNAP

Enrollment/Outreach Question:

1. What can be done to identify and reach out to seniors who are eligible but are not using SNAP?

Corvallis

** Electronic immediate application, facilitated and followed-up (I-pad)

** Train "ground troops" mobile application

** CCO screening, preventative health

- Normalization
- SNAP Brochure
- Public Library Computer Icon
- County Health Dept
- Hospital Discharge
- Grant for mobile outreach
- Tax and bankers
- "State earned income credit model automatic enrollment"
- Medical community
- Hunger identification hunger is different than nutrition

Albany

** Advocate for increase SNAP benefits

- Transportation Issues
    - Schedules
- Flyers in public housing, YMCA and other exercise programs, the bus, doctor's offices, libraries
- Meals on Wheels
- Food pantries (there may be transportation issues on how to get food home)

- Churches, Love INC
- Interfaith Caregivers and others for transportation
- Farmers' Market, coupons incentives

Transportation Questions:

1. What can be done to help with transportation to grocery stores and farmer's markets?
2. What can be done to encourage and support delivery of nutritious foods?

Corvallis

** Neighbors and neighborhood associations, especially high senior populated neighborhoods networking, ride sharing, deliver food to homes (community gardens on-site food pantries part of housing development) have carts available

** Buses transport to common shopping destination

  - Provide social experience

** OSU Extension-outreach and education programs at communities (how to shop on a budget, preserve food)

- Faith based organizations outreach
- Pair up with master gardeners-plant a row
- Housing based food pantries
- Talk to landlords, churches, love INC (volunteers)

Albany

** Enhance Call-A-Ride

  - Saturday and/or Sunday services
  - More "market bus" options including more times and places
  - Recruit more volunteer drivers

** Assist rural markets to provide SNAP, help them fill out paperwork and provide produce

** CSA box for seniors at $12 with produce prepped

- Look into retirement home buses to include community members
- Mobile Markets to housing with high senior populations and/or rural communities

Senior & Disability Services 2012 Focus Groups Summary

As part of the public process during the development of this Area Plan, SDS hosted two focus groups with a variety of local professionals in attendance. A broad range of participants were invited to discuss perspectives and opinions on community issues. These meetings created an atmosphere which encouraged networking and built a sense of community among the senior and disability focused professionals in attendance. These focus groups were well attended and supported by the participants. The first focus group was held on Tuesday, July 24th, 2012, in the upstairs meeting room of Market of Choice located on Circle Boulevard in Corvallis, Oregon, from 5:30-7:30pm. There were 11 individuals in attendance along with OCWCOG's Program Support Supervisor, Project Specialist and Program Manager. The second focus group was held on Monday, July 30th, 2012 in the large conference room at OCWCOG on Queen Avenue in Albany, Oregon also from 5:30-7:30pm. There were 13 individuals in attendance along with OCWCOG's Program Support Supervisor, Project Specialist and Program Supervisor. Below is a list of discussion areas and questions covered at these meetings. Participants also received an agenda and packet of background information.

Discussion Areas and Questions

1. Current Services
    a. What are the most important unmet needs of seniors and people with disabilities we should be aware of as we develop this strategic plan?
    b. Do you have ideas on how these needs can be addressed in the most effective and efficient manner possible?
2. Outreach and Visibility
    a. What is your perception of the parts of our population who are not being adequately served? What subgroups are we not reaching?
    b. What can we do to remedy this gap is services?
    c. What could we do differently in reference to our Aging and Disability Resource Connection (ADRC) to ensure seniors and people with disabilities know how, and where, to find assistance? Senior & Disability Services' ADRC is a 1-800 number with real time live specialists available to sort and refer calls to the appropriate programs or individuals.
3. Baby Boomer Generation
    a. How will our service system and community need to be altered and adapted in order to accommodate this new demographic over the coming years? How can we prepare?

Themes/Outcomes of SDS Focus Groups

- Community need to continue and further support caregivers
- Community need for additional transportation options
- Need for additional SDS accessibility and visibility
- Need for Community Health Navigators and system simplification
- Creating Livable/Sustainable Communities

Record of Group Discussion

** Indicates focal point of conversation

Discussion area #1: Current Services

a. What are the most important unmet needs of seniors and people with disabilities we should be aware of as we develop this strategic plan?
b. Do you have ideas on how these needs can be addressed in the most effective and efficient manner possible?

Corvallis

** Caregiver Needs

Solutions: provide additional respite care, support groups, education, connection to resources and initiate development of care giving coops

** Transportation

Solutions: simplify public transportation system and provide group transportation to community events

- Medication and Pain Management
  Solution: provide additional education
- Social and Emotional Needs
- Hunger, deciding between food or medication
  Solution: implement a Nutrition Risk Assessment to be completed by doctors
- Health Promotion Literacy and Outreach
  Solutions: provide Community Navigators or Community Health Workers, encourage participation in senior care from the whole community, strengthen senior resource and volunteer networks, collaborate with community partners for outreach and to develop resource guides
- SDS Visibility and Marketing

Solutions: diversify information types including large print and magnetic business cards, provide easy access, simplify information, use less acronyms, develop an interactive website with links to and from community partners' pages

- Financial Assistance
  Solutions: develop communal quad style living, encourage shared housing to pool resources

Albany

** System Navigation

Solutions: provide Community Advocates and Navigators which could possibly be volunteer seniors helping seniors, reduce hold and wait time for phone calls and appointments, have a clear Medicaid checklist readily available

** SDS Accessibility

Solutions: expand outreach and marketing to include billboards and television advertising, develop a 1 page cheat sheet of who to call in certain situations, encourage name recognition, put SDS sign on building

- Hunger
- Centralized Community Resource List
  Solutions: develop interactive resource guide where community partners can update information regularly
- Low Income
- Mental Health: financial restrictions, alcohol/drug concerns
  Solution: stop relying on our PD to be the only mental health intervention
- Veteran's Aid
- Public Guardians
- Mental Health
- Caregiver Needs
  Solutions: provide additional training and education
- Education
  Solutions: engage teens and school age children in current SDS focused issues, provide an adult financial refresher course and engage 45-60 age population before they become seniors themselves

The unmet needs identified by both focus groups were: caregiver needs which include respite, a loss of support systems over time, delays in planning for financial

and healthcare needs, a need for increased awareness of resources including Medicare and Medicaid, and a lack of organized advocacy.

The health concerns of caregivers were a major topic of discussion. When caring for a loved one with severe problems, the caregiver's health often becomes the second priority. It is important to recognize this issue, considering that 72% of family caregivers report not going to the doctor as often as they should and 55% say they skip doctor appointments for themselves. Along with this, 63% of caregivers report having poor eating habits and 58% indicate worse exercise habits than before care giving responsibilities (NACE, 2006). In an effort to combat these issues for caregivers, the group brainstormed possible solutions. We need to continue to provide support and educational groups such as Powerful Tools for Caregivers, and provide respite care for attendees. Groups such as these, provide emotional support and an incredible networking opportunity. We need to reach out and let caregivers know about available resources in the community such as Love Inc., Volunteer Interfaith Caregivers, Senior Companions and Adult Foster Homes. This outreach needs to be aimed at consumers and community partners. Very practical ideas such as helping families build rotating care schedules or developing caregiver coops could prove effective in relieving caregiver stress.

Another unmet need is transportation. Our current public transportation system is too complicated for older adults. Those portions of the system that cater specifically to seniors are overloaded and unable to serve everyone, therefore, the transportation system ends up having to prioritize services based on need. Often, the last priority on this list is social, leisure and recreational activities. This can affect the overall well-being of older adults, consequently seniors, who often hold on to their driver's licenses beyond a point of safe driving due to their fear of being isolated and dependent on others. One solution mentioned is that our communities make a greater effort to provide group transportation through senior living facilities and senior centers to special events around the region.

A recurring theme during the discussion of unmet needs was the need for Community Health Workers and/or Health Navigators. Our service delivery system has a lack of service integration and coordination. There are an overwhelming number of options, with no way to know which is best for your situation. Community Health Workers and Health Navigators would provide knowledgeable professionals in the community who could advocate for consumers and help find appropriate services for each unique situation. Consumers often report how fragmented and confusing the service delivery system can be. They have trouble with application processes, understanding insurance, and getting connected to resources.

One concerning theme discussed during the Albany focus group was Veteran's benefits. This is another instance when transportation becomes a huge barrier. Many Veterans services are located in the Portland Metropolitan area, which poses a problem to Linn, Benton and Lincoln County residents. Consumers also report how confusing this system can be. There are navigators available to help through this process, but the wait time for such help is an important consideration. Veterans often end up paying private companies to expedite this process.

Discussion Area #2: Outreach and Visibility

a. What is your perception of the parts of our population who are not being adequately served? What subgroups are we not reaching?

b. What can we do to remedy this gap is services?

c. What could we do differently in reference to our Aging and Disability Resource Connection (ADRC) to ensure seniors and people with disabilities know how, and where, to find assistance? Senior & Disability Services' ADRC is a 1-800 number with real time live specialists available to sort and refer calls to the appropriate programs or individuals.

Corvallis

** Homebound or otherwise isolated individuals

** Anti-labelers avoiding the stigma of being "senior" or "old"

Solution: redefine "senior" within our community

- Individuals without family support/advocates
- Minority ethnic populations: Latino
  Solution: address language and cultural barriers
- "Greatest Generation" overshadowed by "Baby Boomers"
  Solutions: be cautious of overusing technology, outreach rather than waiting for them to come to us
- Uneducated
- Disempowered
- School age children caring for grandparents
  Solutions: engage and connect the entire community, OSU would be a great first step

Albany

** Homebound or isolated individuals: rural and urban

Solutions: provide transportation options and newspaper subscriptions

** Individuals who fall in the income gaps between private and public services

Solution: offer non-income qualifying system navigation services

- Non-tech savvy
- Minority Ethnic groups: Hispanic, Russian
  Solution: have information in multiple languages and translators to combat language barriers
- Mentally Ill
- Bariatric population
  Solutions: provide education to local professionals and encourage additional living options

General Outreach and Viability Solutions:

1. Increase SDS marketing. This could include billboard advertisement or television commercials. Attending community events such as chamber, library and senior center events would substantially increase visibility. We need to let people know who we are and what we do. Two prime outreach opportunities identified in our community are doctors' offices and churches. It was suggested multiple times that we should have a SDS sign on our building, rather than just the OCWCOG sign.

2. Develop and support Neighborhood Associations or Neighborhood Watch Groups including shared neighborhood information and involvement of the local PD. Encourage a community where neighbors watch out for each other and services are integrated into daily life rather than stigmatized. Emphasize the community values of helping one another and civic responsibility.

3. Develop a senior focused community email list to keep community partners connected. Send monthly interesting facts, make sure partners are stocked with brochures and updated information regularly. From this updated information, develop a collaborative resource list.

4. Senior centers host monthly "Ask a Professional" meetings, where a panel of qualified senior focused professionals and local organizations would be present to answer consumers' questions.

5. Only approximately half of those in attendance knew of the ADRC. Of those who had utilized the service in the past, recommendations included adding evening/weekend hours, shortening hold times, linking the service to community partners' websites, getting a library web link button and marketing through brochure distribution.

Discussion Area #3: Baby Boomer Generation

a. How will our service system and community need to be altered and adapted in order to accommodate this new demographic over the coming years? How can we prepare?

Corvallis & Albany

- Recognize that this generation needs to be engaged differently. Consider workplace outreach and targeting employers. Multimedia marketing is a key to connecting with Baby Boomers' communication style. We will be more able to rely on internet access. Suggestions included acquiring a QRC code to print on brochures, developing a Facebook page, improving our website to be more user friendly and hosting monthly webinars.
- This population does not want to be thought of as "old". We need to begin redefining "old" as "aging" and remove the stigma attached with this natural process.
- Keep in mind the shifting views about monetary priorities, physical activity, postponed retirement, retirement expectations, volunteer opportunities, community involvement, social and emotional needs and health care.
- Simplify application and maintenance processes in order to accommodate a much higher volume of individuals and families.
- This generation places high value on education. Consider providing continuing education credits through LBCC.
- More housing options will be necessary. Co-housing and community integration fit well with this population's priorities.

Senior & Disability Services 2010 Family Caregiver Survey

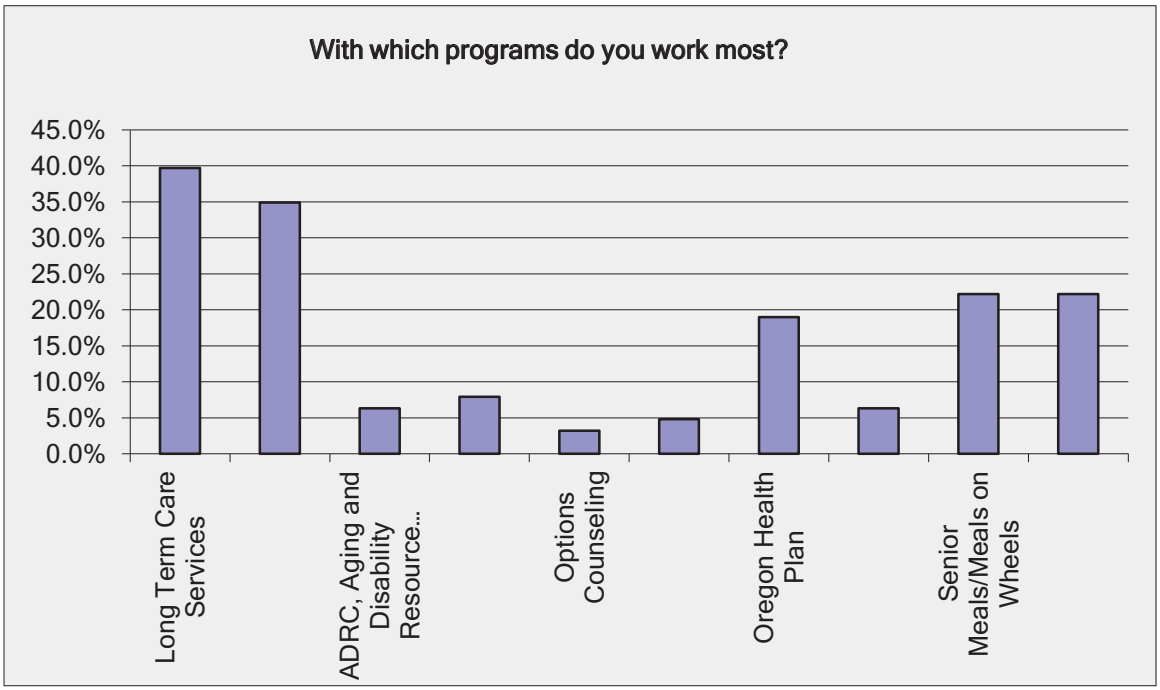
A Caregiver Support Survey was conducted in 2010 to gather feedback and identify existing gaps in service for those being served in Linn and Benton Counties. There was a 67% return rate on the survey after mail, telephone, and in-person contact. Results from the survey were overwhelmingly positive and encouraging of this program's potential. Based on these survey results, the mean age of caregivers we serve is 70 years of age. The mean age of the person in care is 83 years of age, excluding the four individuals under 18 years of age. Of our caregivers, 88% report caring for a person 60 or over, 52% report caring for a person with Alzheimer's or Dementia, 24% report caring for an adult or child with a disability and 5% report caring for a related child 18 or younger. 83% of caregivers who responded reported that their contact with the FCSP was "Very Helpful". Of the services offered by the FCSP, caregivers reported utilizing the following in order from most commonly utilized to least:

- Information about Services
- Respite
- Help Obtaining Services
- Caregiver Training
- Support Groups

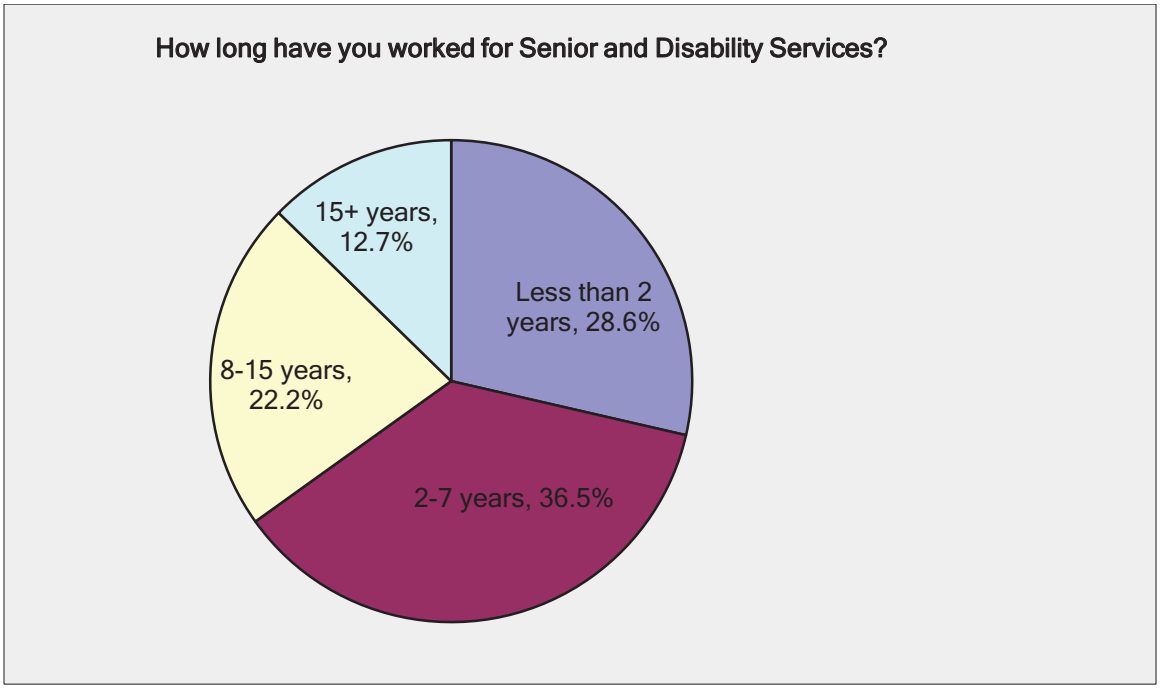
When asked to rate the services they received, 76% or caregivers rated as "Excellent" and another 18% rated services as "Good". 57% of those who received respite care commented that they needed a longer break. Since the survey, this has become a focus area in the program. When asked if the support services received helped them be a better caregiver, 89% of those who responded said yes. The same percentage (89%) also reported that the services they received helped to keep their loved one living at home. Caregivers were given a chance to comment on what they experience mentally and emotionally throughout the care giving process. These answers ranged broadly from joy to exhaustion and everything in between. When asked what is most helpful to caregivers, the vast majority prioritized respite care and encouragement/emotional support at the top of their list. There were a wide variety of answers to the question of what is most satisfying about being a caregiver, but the two most common answers included "bringing comfort to a loved one" and "keeping my loved one out of nursing home care." Considering these results has given coordinators direction when planning the program budget and activities for individuals they serve.

Senior & Disability Services 2012 Staff Survey

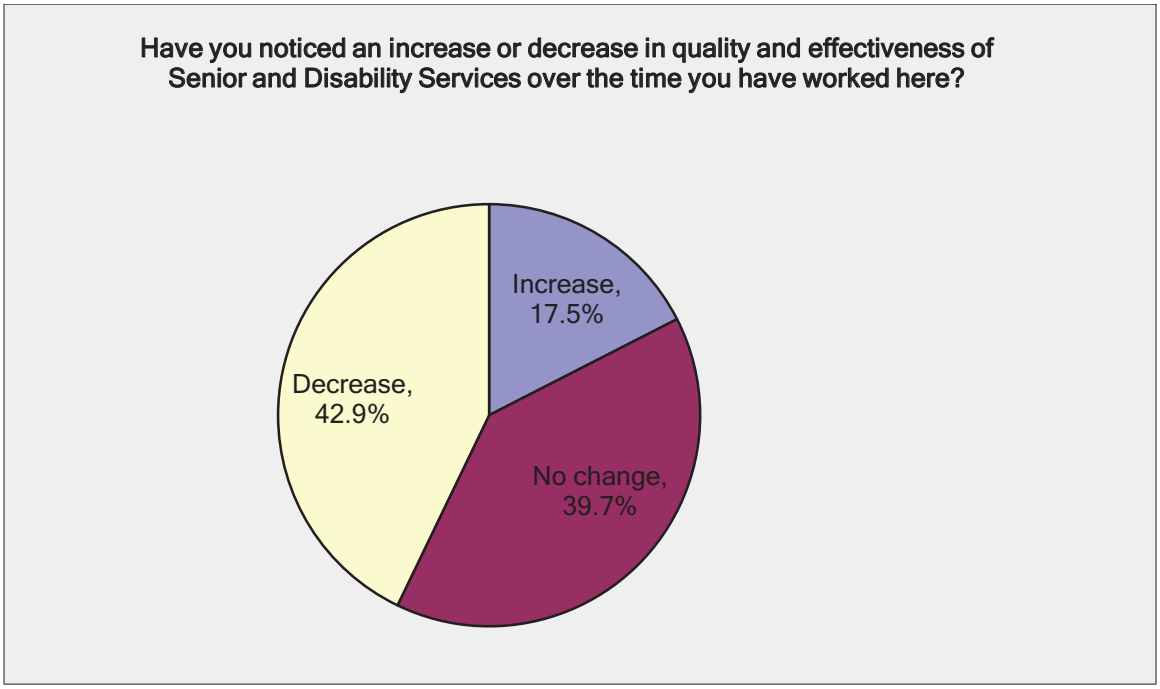
1. With which programs do you work most?		
Answer Options	**Response Percent**	**Response Count**
Long Term Care Services	39.7%	25
Food Benefits	34.9%	22
ADRC, Aging and Disability Resource Connections	6.3%	4
Oregon Project Independence	7.9%	5
Options Counseling	3.2%	2
Family Caregiver Support Program	4.8%	3
Oregon Health Plan	19.0%	12
Adult Protective Services	6.3%	4
Senior Meals/Meals on Wheels	22.2%	14
Other	22.2%	14
	answered question	63
	skipped question	0



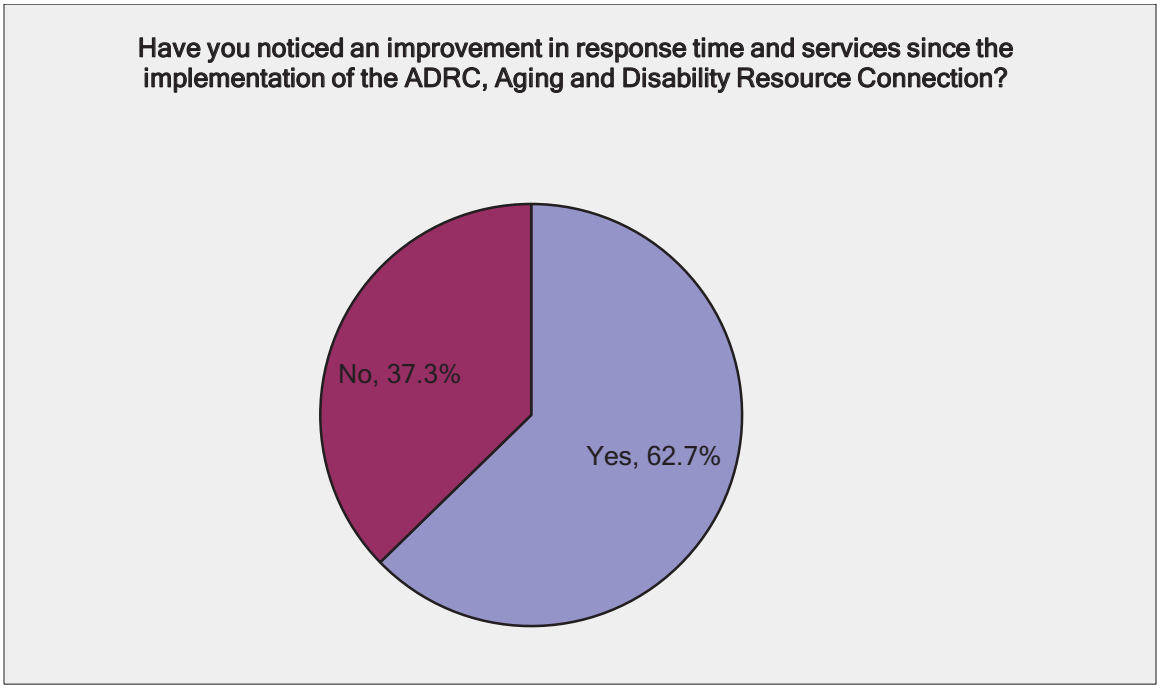
2. How long have you worked for Senior and Disability Services?		
Answer Options	**Response Percent**	**Response Count**
Less than 2 years	28.6%	18
2-7 years	36.5%	23
8-15 years	22.2%	14
15+ years	12.7%	8
	answered question	**63**
	skipped question	**0**



3. Have you noticed an increase or decrease in quality and effectiveness of Senior and Disability Services over the time you have worked here?		
Answer Options	**Response Percent**	**Response Count**
Increase	17.5%	11
No change	39.7%	25
Decrease	42.9%	27
	answered question	63
	skipped question	0

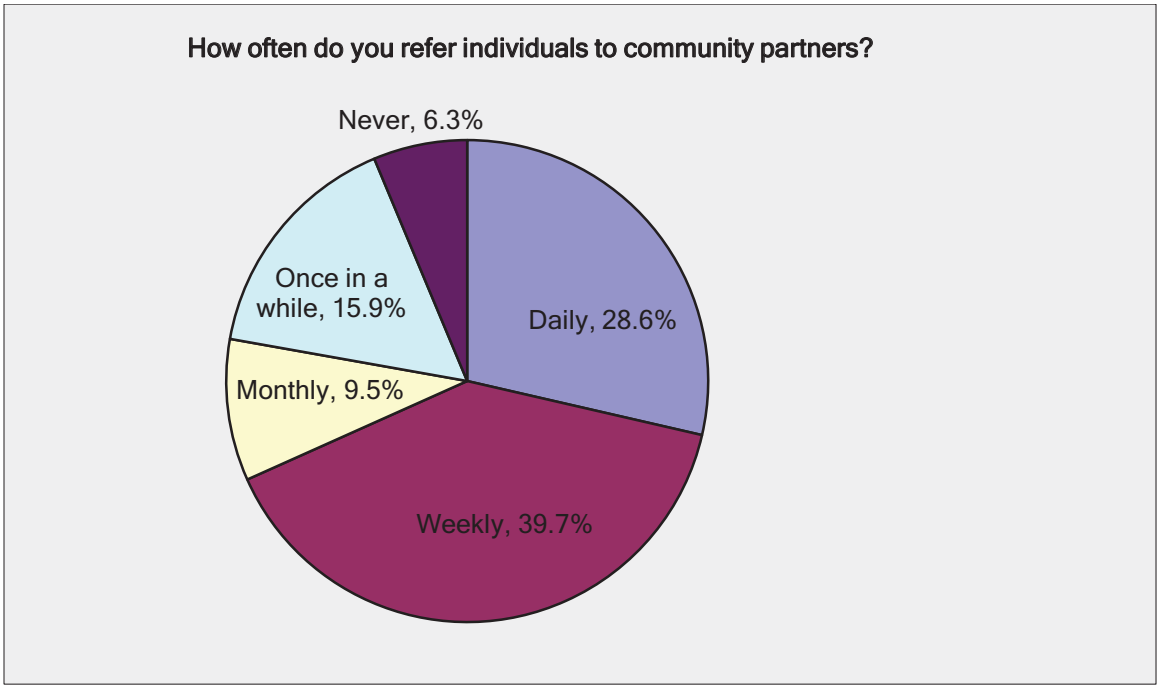


4. Have you noticed an improvement in response time and services since the implementation of the ADRC, Aging and Disability Resource Connection?		
Answer Options	**Response Percent**	**Response Count**
Yes	62.7%	37
No	37.3%	22
	answered question	59
	skipped question	4

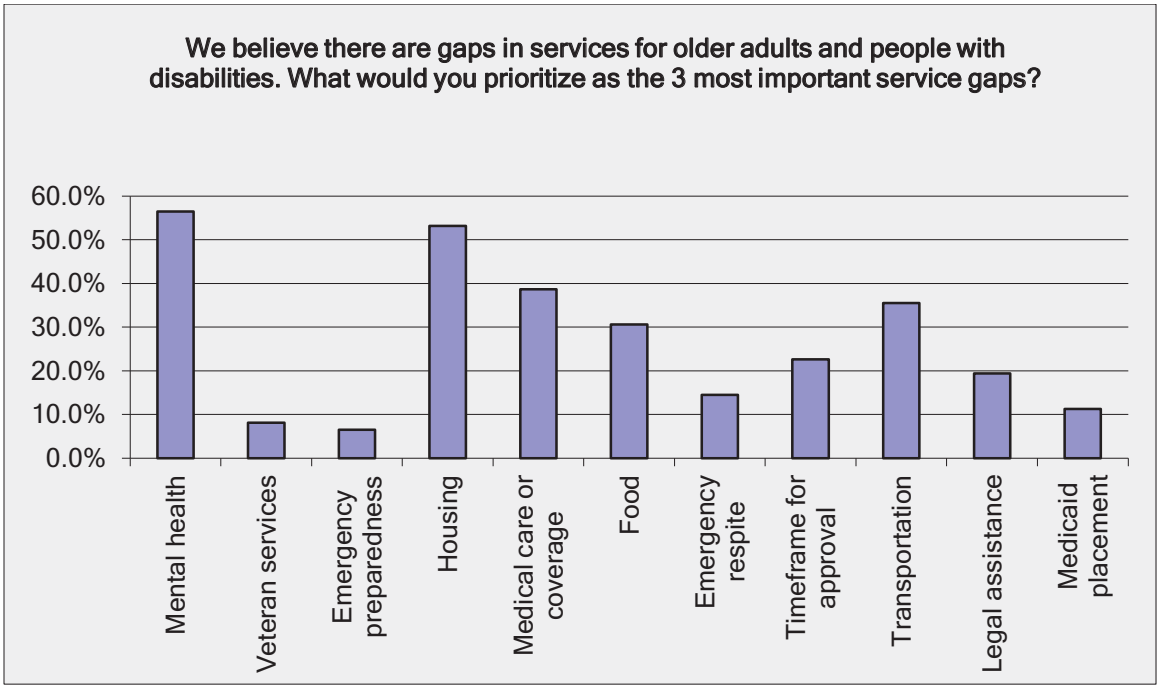


5. Once Senior and Disability Services responds to a referral, please rate how effectively we assist clients.												
Answer Options	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Rating Average**	**Response Count**
	0	0	0	1	3	6	17	23	6	1	7.40	57
											answered question	57
											skipped question	6

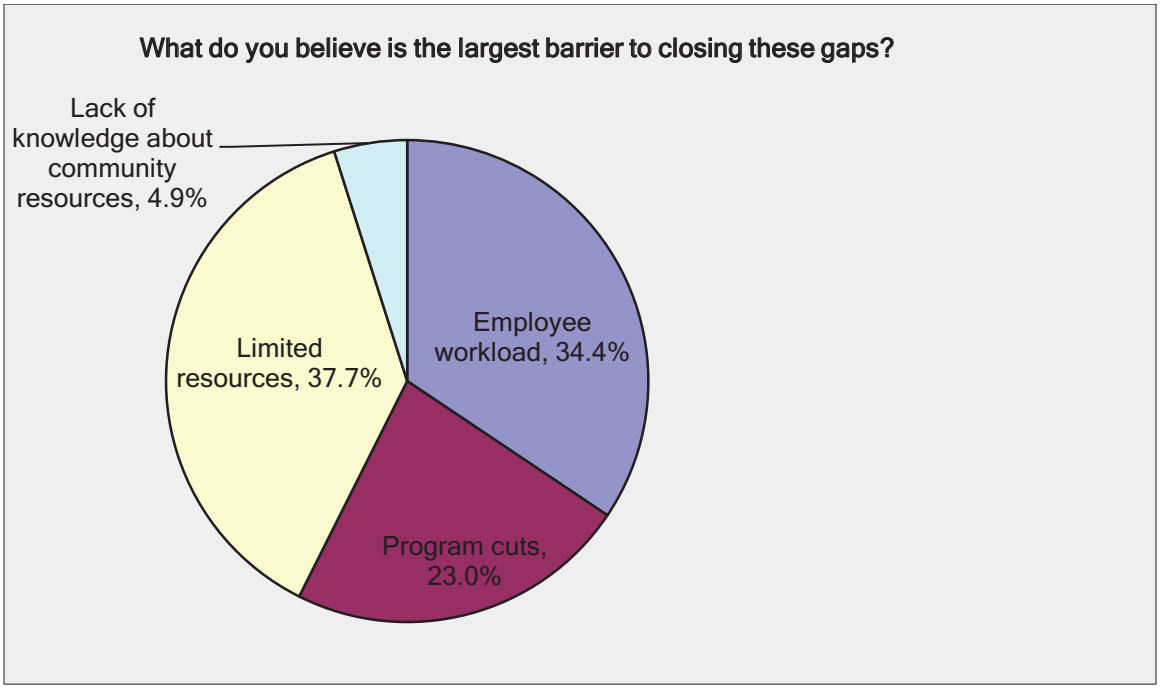
6. How often do you refer individuals to community partners?		
Answer Options	**Response Percent**	**Response Count**
Daily	28.6%	18
Weekly	39.7%	25
Monthly	9.5%	6
Once in a while	15.9%	10
Never	6.3%	4
	answered question	63
	skipped question	0



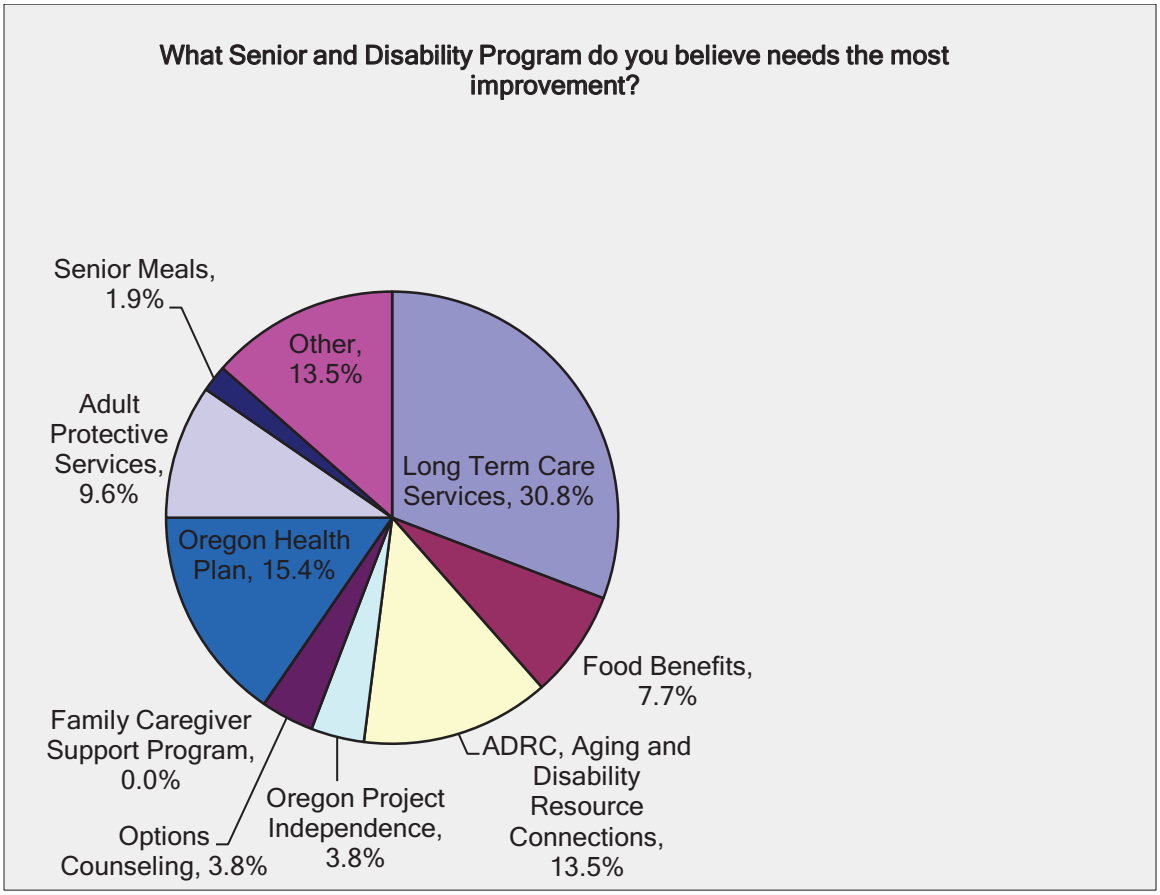
7. We believe there are gaps in services for older adults and people with disabilities. What would you prioritize as the 3 most important service gaps?		
Answer Options	**Response Percent**	**Response Count**
Mental health	56.5%	35
Veteran services	8.1%	5
Emergency preparedness	6.5%	4
Housing	53.2%	33
Medical care or coverage	38.7%	24
Food	30.6%	19
Emergency respite	14.5%	9
Timeframe for approval	22.6%	14
Transportation	35.5%	22
Legal assistance	19.4%	12
Medicaid placement	11.3%	7
Other (please specify)		5
	answered question	62
	skipped question	1



8. What do you believe is the largest barrier to closing these gaps?		
Answer Options	**Response Percent**	**Response Count**
Employee workload	34.4%	21
Program cuts	23.0%	14
Limited resources	37.7%	23
Lack of knowledge about community resources	4.9%	3
Other (please specify)		6
	answered question	61
	skipped question	2



9. What Senior and Disability Program do you believe needs the most improvement?		
Answer Options	**Response Percent**	**Response Count**
Long Term Care Services	30.8%	16
Food Benefits	7.7%	4
ADRC, Aging and Disability Resource Connections	13.5%	7
Oregon Project Independence	3.8%	2
Options Counseling	3.8%	2
Family Caregiver Support Program	0.0%	0
Oregon Health Plan	15.4%	8
Adult Protective Services	9.6%	5
Senior Meals	1.9%	1
Other	13.5%	7
Why?		34
	answered question	52
	skipped question	11



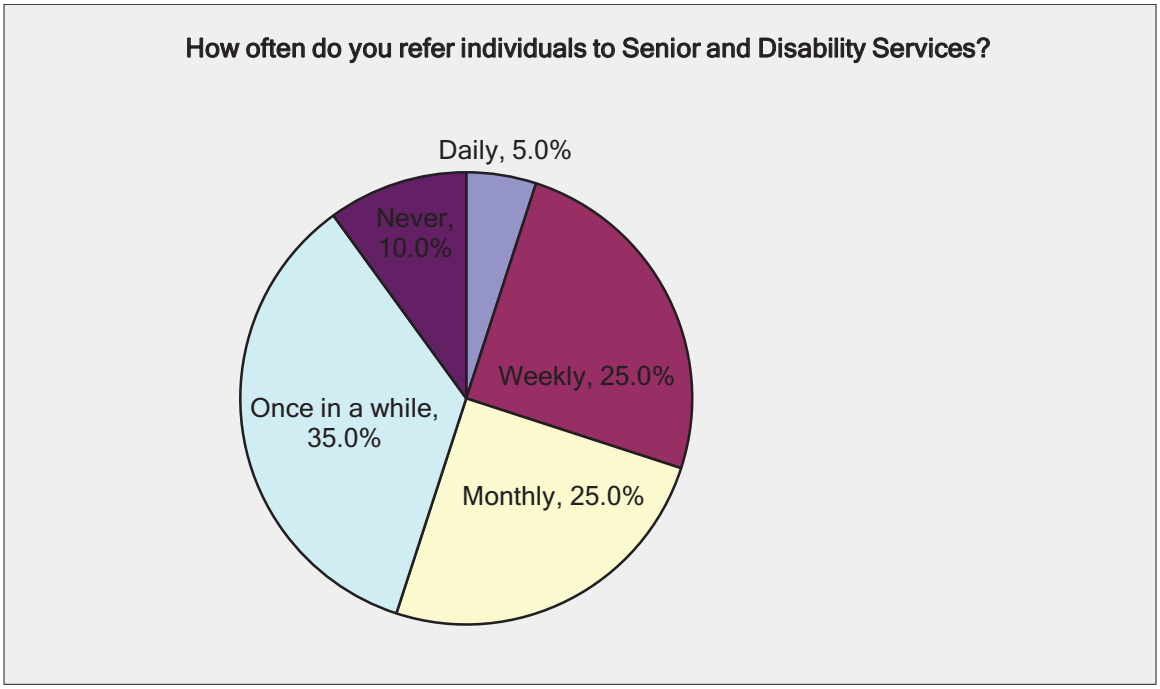
10. How do you feel we could be more helpful to our community partners and/or clients?	
Answer Options	Response Count
	28
answered question	28
skipped question	35

Answers:

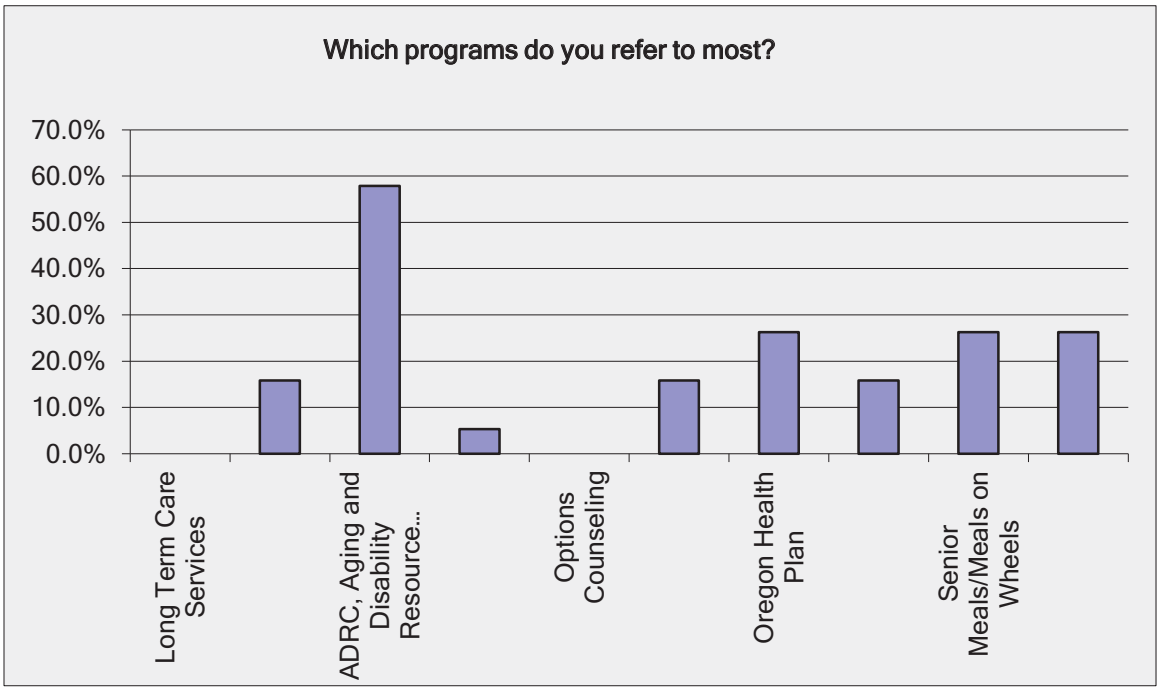
1. To know what is really available out there
2. Better partnership with County Mental Health
3. Providing all staff with current knowledge about community resources
4. Make the brand OCWCOG more widely known
5. Be sure they know what programs are available
6. Increase staff
7. More staff will help ease the workload and backlog of calls
8. Get rid of the ADRC
9. Make resources known to employees and clients
10. More resources
11. Adequate staff so that there is more time to spend on individual clients
12. Hire more staff
13. Educate staff about community partners and resources
14. Smaller caseloads
15. More staff
16. Additional time
17. Reduce paper work
18. Get to know community partners
19. Assign one CM to process all hospitalized clients' applications to help facilitate a faster discharge
20. More man power
21. Better communication between agencies
22. Educate staff about resources
23. Reduce caseloads
24. Eliminate hours of non-essential positions
25. Lower caseloads
26. Smaller caseloads
27. Decrease caseloads
28. Reduction in caseloads

Senior & Disability Services 2012 Community Partner Survey

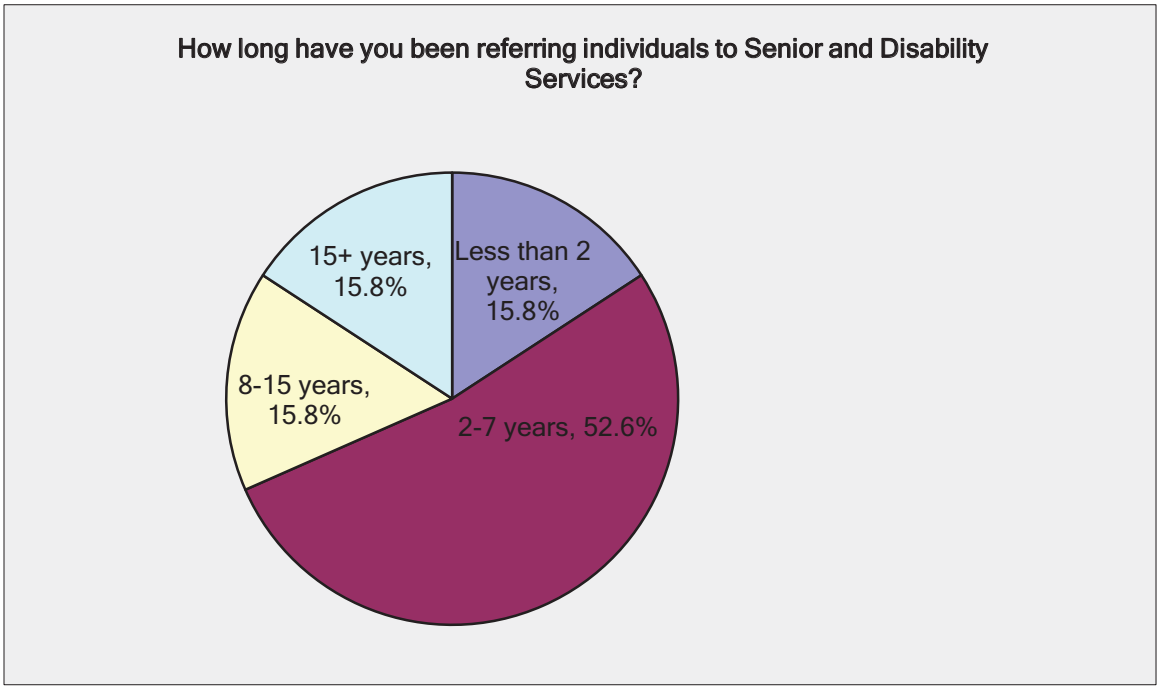
1. How often do you refer individuals to Senior and Disability Services?		
Answer Options	**Response Percent**	**Response Count**
Daily	5.0%	1
Weekly	25.0%	5
Monthly	25.0%	5
Once in a while	35.0%	7
Never	10.0%	2
answered question		20
skipped question		0



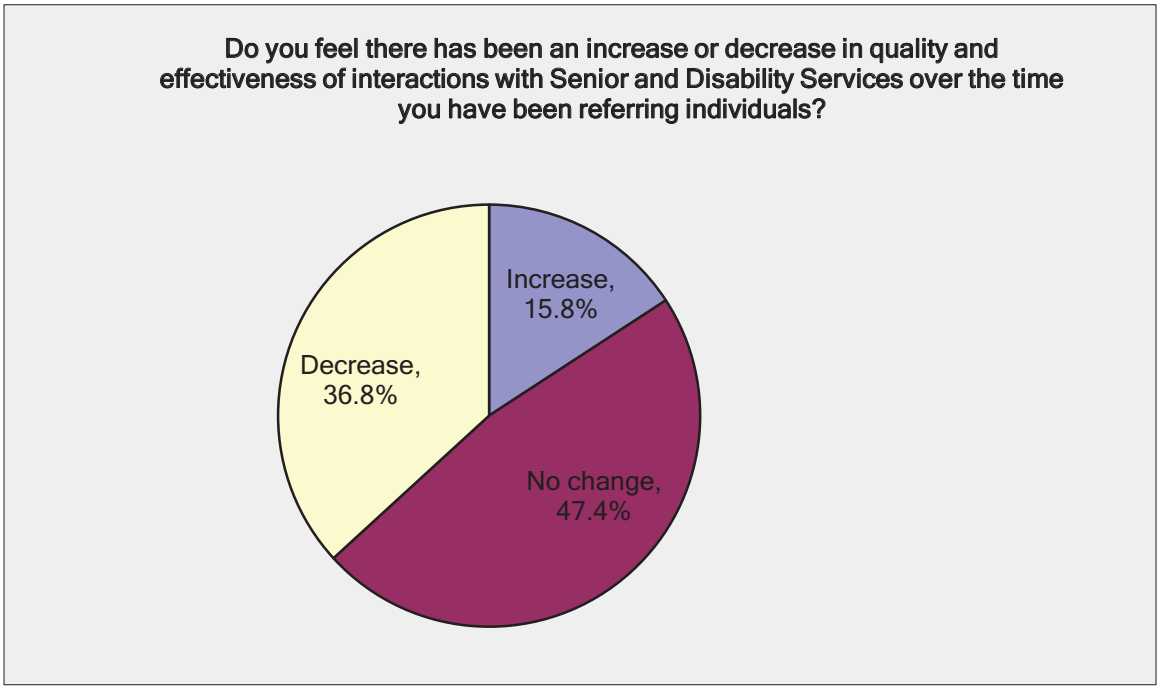
2. Which programs do you refer to most?		
Answer Options	**Response Percent**	**Response Count**
Long Term Care Services	0.0%	0
Food Benefits	15.8%	3
ADRC, Aging and Disability Resource Connections	57.9%	11
Oregon Project Independence	5.3%	1
Options Counseling	0.0%	0
Family Caregiver Support Program	15.8%	3
Oregon Health Plan	26.3%	5
Adult Protective Services	15.8%	3
Senior Meals/Meals on Wheels	26.3%	5
Other	26.3%	5
	answered question	19
	skipped question	1



3. How long have you been referring individuals to Senior and Disability Services?		
Answer Options	**Response Percent**	**Response Count**
Less than 2 years	15.8%	3
2-7 years	52.6%	10
8-15 years	15.8%	3
15+ years	15.8%	3
	answered question	19
	skipped question	1



4. Do you feel there has been an increase or decrease in quality and effectiveness of interactions with Senior and Disability Services over the time you have been referring individuals?		
Answer Options	**Response Percent**	**Response Count**
Increase	15.8%	3
No change	47.4%	9
Decrease	36.8%	7
To what do you attribute this change?		9
	answered question	19
	skipped question	1



5. Please rate the responsiveness and timeliness of Senior and Disability Services staff once a referral is made, 1 being poor and 10 being excellent?

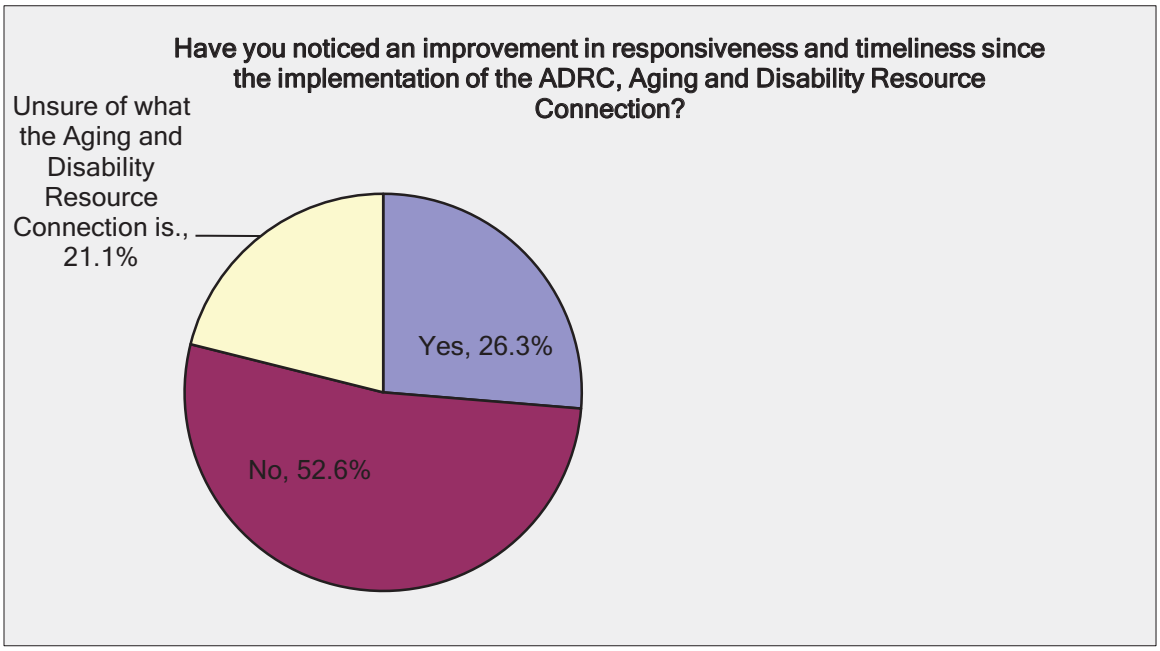
Answer Options	1	2	3	4	5	6	7	8	9	10	Rating Average	Response Count
	0	0	0	1	3	4	6	4	0	0	6.50	18
											answered question	18
											skipped question	2

6. Please rate the effectiveness of Senior and Disability Services programs in serving individuals you have referred, 1 being poor and 10 being excellent.

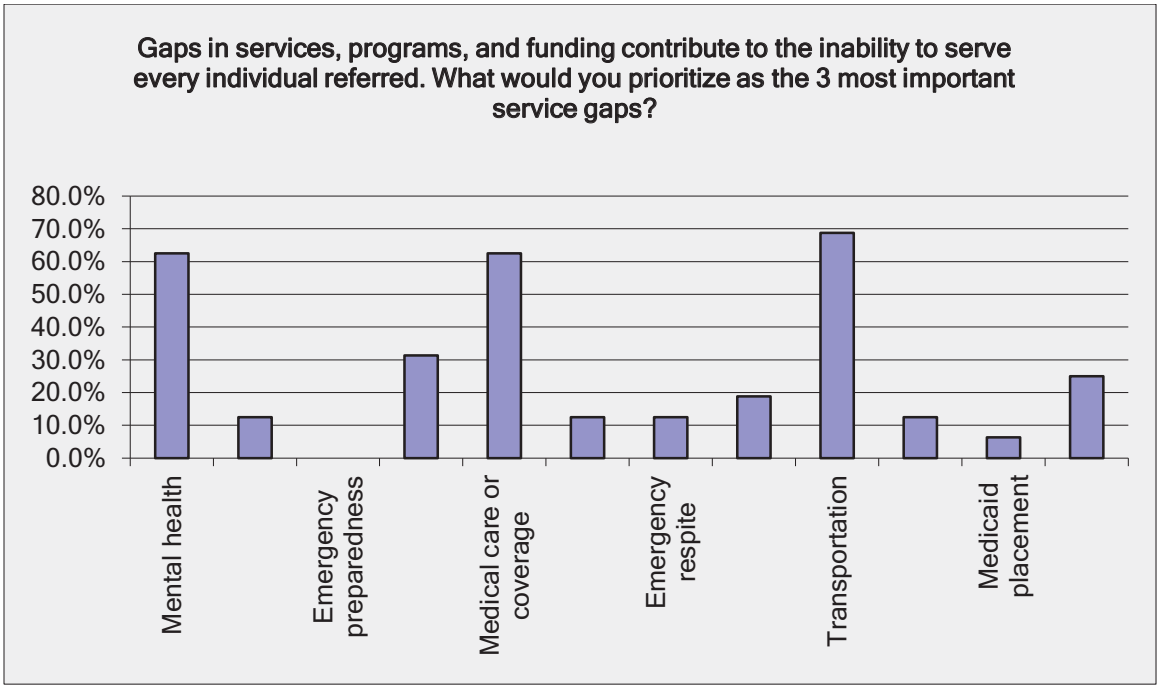
Answer Options	1	2	3	4	5	6	7	8	9	10	Rating Average	Response Count
	0	0	0	2	1	5	5	5	0	0	6.56	18
											answered question	18
											skipped question	2

7. Have you noticed an improvement in responsiveness and timeliness since the implementation of the ADRC, Aging and Disability Resource Connection?

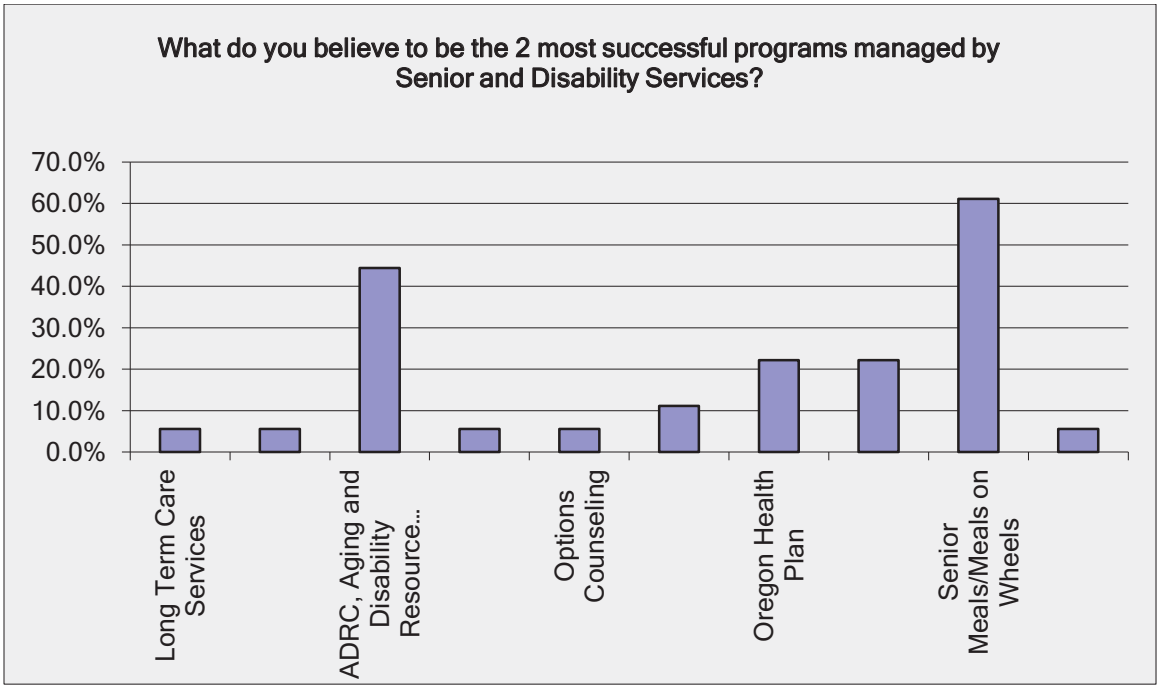
Answer Options	Response Percent	Response Count
Yes	26.3%	5
No	52.6%	10
Unsure of what the Aging and Disability Resource Connection is.	21.1%	4
answered question		19
skipped question		1



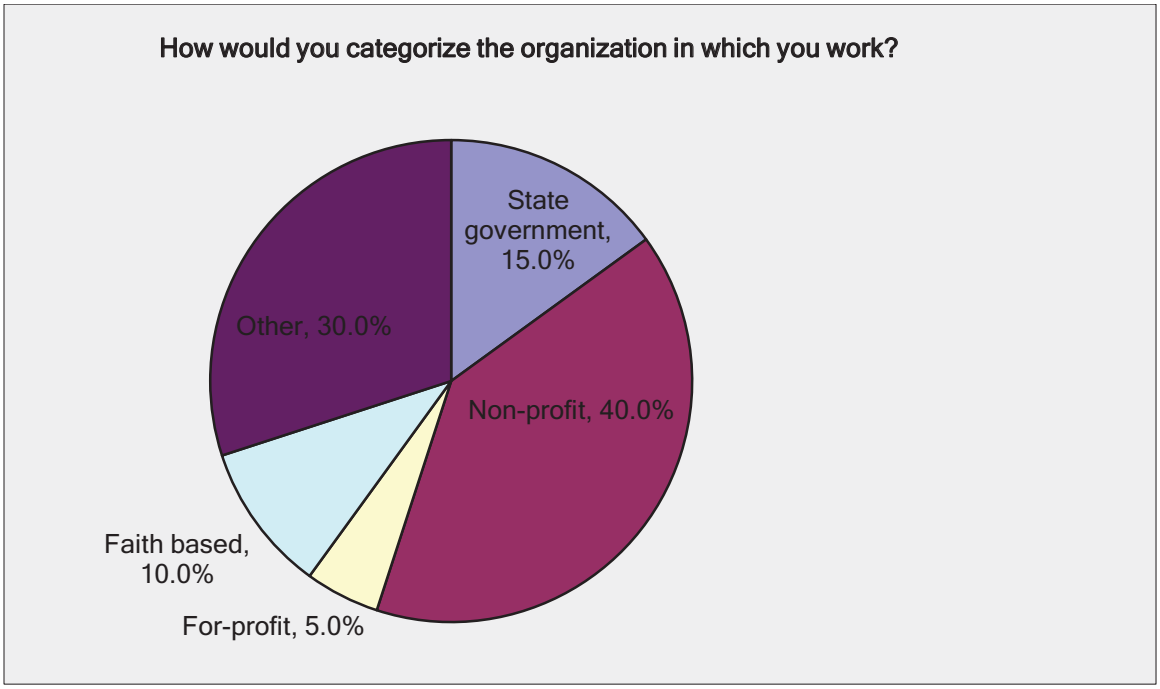
8. Gaps in services, programs, and funding contribute to the inability to serve every individual referred. What would you prioritize as the 3 most important service gaps?		
Answer Options	**Response Percent**	**Response Count**
Mental health	62.5%	10
Veteran services	12.5%	2
Emergency preparedness	0.0%	0
Housing	31.3%	5
Medical care or coverage	62.5%	10
Food	12.5%	2
Emergency respite	12.5%	2
Timeframe for approval	18.8%	3
Transportation	68.8%	11
Legal assistance	12.5%	2
Medicaid placement	6.3%	1
Community outreach and referral	25.0%	4
To what do you attribute these gaps?		5
	answered question	16
	skipped question	4



9. What do you believe to be the 2 most successful programs managed by Senior and Disability Services?		
Answer Options	**Response Percent**	**Response Count**
Long Term Care Services	5.6%	1
Food Benefits	5.6%	1
ADRC, Aging and Disability Resource Connections	44.4%	8
Oregon Project Independence	5.6%	1
Options Counseling	5.6%	1
Family Caregiver Support Program	11.1%	2
Oregon Health Plan	22.2%	4
Adult Protective Services	22.2%	4
Senior Meals/Meals on Wheels	61.1%	11
Other	5.6%	1
	answered question	18
	skipped question	2



10. How would you categorize the organization in which you work?		
Answer Options	**Response Percent**	**Response Count**
State government	15.0%	3
Non-profit	40.0%	8
For-profit	5.0%	1
Faith based	10.0%	2
Other	30.0%	6
	answered question	**20**
	skipped question	**0**



2011 Senior & Disability Consumer Survey

This survey was sent via paper mail to individuals served within in our tri-county area. Of the 9,000 individuals who received the survey, 904 responded.

Tally Sheet (Tell Us How We're Doing)

Are you a...?

Current Client	827	91%
New Applicant	16	2%
Provider	23	3%
Seeking info	13	1%
Did not answer	25	3%
Total	904	

How did you make contact with us?

In Person	419	46%
Via the phone	393	43%
By mail	1	0%
Both	35	4%
Did not answer	56	6%
Total	904	

Were you treated courteously?

Yes	868	96%
No	13	1%
Both	3	0%
Did not answer	20	2%
Total	904	

Were you helped in a reasonable amount of time?

Yes	850	94%
No	26	3%
Both	1	0%
Did not answer	27	3%
Total	904	

Did you get the information you needed?

Yes	844	93%
No	36	4%
Both	2	0%
Did not answer	22	2%
Total	904	

Where were you served?

Albany	539	60%
Corvallis	74	8%
Lebanon	11	1%
Lincoln City	7	1%
Lyons	1	0%
Newport	9	1%
Sweet Home	5	1%
Toledo	230	25%
Waldport	1	0%
Yachats	1	0%
Did not answer	26	3%
Total	904	

How would you rate your contact with Senior Services?

Excellent	510	56%
Good	300	33%
Average	55	6%
Not Satisfied	25	3%
Did not answer	14	2%
Total	904	

Page 1

Tally Sheet (combined)

Tally Sheet (Tell Us What You Think)

How do you get around?	RANK 1	2	3	4	5	6	7
My Own Car	379	12	0	0	0	0	0
City Bus	22	17	9	3	0	0	1
Dial-a-Ride	59	27	7	1	1	0	0
Ride with Friend or Family	187	125	11	0	1	0	0
Walk	31	69	23	5	0	0	2
Senior Companion	42	18	5	2	0	1	0
Taxi	1	9	9	5	1	3	0

What is your current living situation?		
Renting my own place	346	43%
Nursing Home, ALF or AFC	110	14%
Own my own home	203	25%
Homeless	1	0%
Living with friends or family	101	13%
Other	24	3%
Did not answer	13	2%
Total	798	

Is your housing situation safe?		
Yes	736	92%
No	35	4%
Did not answer	27	3%
Total	798	

Do you feel you are adequately prepared for a disaster?		
Yes	505	63%
No	206	26%
Did not answer	87	11%
Total	798	

Is your housing situation affordable?		
Yes	662	83%
No	81	10%
Did not answer	55	7%
Total	798	

Is your housing wheelchair accessible?		
Yes	343	43%
No	361	45%
Did not answer	94	12%
Total	798	

Changes	Better	Same	Worse	No Answer	Total
Housing	155	541	66	36	798
Medical Care	170	521	79	28	798
Transportation	83	599	72	44	798
Food Resources	143	562	72	21	798
Clothing	68	625	71	34	798

Unmet Needs	RANK 1	2	3	4	5	6	7
Bathing	29	4	10	1	1	1	0
Transportation	65	35	13	1	0	0	0
Medical	85	27	6	0	1	0	0
Housing	26	19	15	0	2	0	0
Food & Clothing	32	35	32	2	1	0	0
Recreation	43	20	22	0	0	3	0
Other	20	10	8	1	0	0	1

Appendix D Report on Accomplishments from 2011-2012 Area Plan Update

1. *Continue to explore various ways of increasing the availability of evidence based programs in our region:* We have completed a regional coordination grant for the Chronic Disease Self Management Program, CDSMP. Healthy aging forums were conducted by the Healthy Aging Coalition (HAC) in Corvallis, Albany and Lebanon.

2. *Develop emergency and disaster planning activities with each of the three counties in our region:* We continue to work on internal processes for emergency planning, for staff and for our clients. A list of our most vulnerable clients is printed quarterly and distributed to all managers and to each office safe to utilize in case of an emergency situation. These lists will guide necessary emergency relief to any of our clients who will need assistance quickly due to care requirements. Key staff participates in 'vulnerable population' workgroups in each county. OCWCOG has an emergency plan in place for how to continue operations in an event of an emergency. This plan is continuously reviewed and revised as appropriate.

3. *Work to modernize senior nutrition services throughout our region:* This goal has been discontinued.

4. *To improve the ADRC visibility and function in the Linn, Benton, and Lincoln areas*: OCWCOG hosted an open house to launch our ADRC opening in Linn/Benton counties in February of 2011 and Lincoln county in March of 2011. There has been extensive marketing including brochures, posters, business cards and bookmarks, which have been made available to the community. The ADRC has also been advertised in the newspaper and during presentations by our managers, ADRC staff and Options Counselors.

5. *Improve the outreach program in our region:* Several improvements have been made in the number of presentations and meetings that our staff has attended in the community.

6. *Improve Family Caregiver Support Program:* There has been increased community networking such as FCSP recognition and resource fairs in each of our three counties. OAA case managers continue to market this program through public presentations to community partners and the public.

7. *Evaluate feasibility of working with one or more communities in our region on development of a community strategic plan:* The project 'livable communities' is on hold due to the economic restrictions in our region.

8. *Continue to expand ongoing public information to increase community awareness of Senior Services:* The *Generations* publication is distributed quarterly to approximately 33,000 homes in our tri-county region. Our staff currently serve on the SUA/ADRC grant sponsored IT committee to rollout the ADRC of Oregon website. Key staff is responsible for updating local resources within the website and reaching out to community organizations that are not yet included. There has been a statewide marketing effort to promote the ADRC and Options Counseling by using local media and handouts such as brochures and bookmarks. There has been an increase in presentations to partners, non-profits and civic organizations.

9. *Maintain up to date procedure manuals; convert all to intranet based documents*: We are currently reinventing the agency website to be more contemporary and user friendly. Internally, we are working on a shared drive where policy manuals, procedures and processes will be stored for easy staff access. We have an Internal Operations Committee that works on creating consistent procedures across our region, as well as multiple internal workgroups that meet periodically to ensure the monitoring and upkeep of such procedures.

10. *Maintain a well-trained staff to insure quality services for growing client population:* We continue to identify training needs as policies and staff change. We have training curriculums in place for each unit of work and are currently developing a shared drive where policy manuals, procedures and processes will be stored for easy staff access. OCWCOG continues to request more frequent statewide trainings to insure staff is consistently trained as policy and statewide processes change.

11. *Increase efficiency of staff and computer systems to provide the highest quality of services for the least cost:* Each Eligibility Worker now has a dual monitor system, which has dramatically increased the efficiency in their work. While some State systems have decreased efficiency due to lack of maintenance, our Quality Assurance (QA) manager actively participates in 'Change Leader' meetings to learn about the modernization of DHS's programs in an effort to provide accessibility and ease to our clients. We currently work with the Client Application Processing Interface (CAPI) to

process online applications. An increased amount of clients are using this as a way to apply for benefits because of its high convenience level.

Lincoln County has integrated all case management and eligibility tasks into one position, which has proved to provide elevated customer service to our clients. Linn and Benton Counties are currently working in a phased process to do the same.

The QA manager continues to work with various groups on process mapping and Rapid Process Improvement (RPI). Various work units have 'huddles' in an effort to stay connected, share current policy and problem solve.

12. *Continue long and short term planning for SDS to meet the needs of these populations now into the future:* OCWCOG distributed and evaluated staff, community partner and client surveys. Community forums were held in each of the three counties served by OCWCOG to solicit information about the needs and solution ideas in each community. Focus groups were held in Corvallis and Albany in an effort to gather new ideas and collaborate with community partners in our planning process. SDS managers meet periodically to discuss how our agency can better meet the needs of our communities.

13. *Increase funding for senior programs to help meet the demands for services:* Senior meals has continued to be successful in securing grants and community donations to support the program. In addition, we have received grants for ADRC operational improvements, expanding the RSVP services with grants and work continues with the Senior Services Foundation to bring additional donations to the programs.

14. *Maintain and develop new contract relationships to assist offering more services to seniors by utilizing community partners*: SDS maintains contract relationships with Legal Aid Services of Oregon and Grace Adult Day Center as well as Memorandums of Understanding (MOU) with 211, Interfaith Volunteer Caregivers and Samaritan's Senior Companion Program.

15. *Continue to partner with LCOG and NorthWest Seniors and People with Disabilities in contracting for In Home Services and Senior Meals:* We jointly use kitchen facilities and food providers for the Meals on Wheels food service contract. OCWCOG has a joint in-home service contract to

provide care to all clients in our regions. Partnerships with our sister agencies continue to be positive and productive relationships.

16. *Advocate for maintaining and improving upon a comprehensive system for seniors and people with disabilities*. SDS accomplishes this through presentations throughout the community. At the State level, this is accomplished by speaking directly with legislators and requesting that they present to our staff and advisory councils. Nationally, advocating is provided by N4A and MOWAA and other national organizations. This is an ongoing challenge for staff, managers and Director.

17. *Maintain ongoing interagency coordination and communication between Senior Services and other groups and agencies that serve seniors:* SDS continues to use the ADRC resource database, update information as appropriate, participate in community resource fairs and conduct presentations in our region. We work closely with other agencies serving seniors in our community such as RSVP, SHIBA, Interfaith Volunteer Caregivers and local senior centers.

18. *Create public awareness for Senior Services and the services we offer to seniors in the region:* Presentations are made regularly in the community to provide information about the ADRC and services we offer to the public. ADRC specialists receive phone calls, faxes, emails and letter inquiries from individuals in the community and are responsive to provide information on services our agency provides, as well as referrals to community agencies. *Generations* is a quarterly publication of the local newspapers provided to 33,000 homes. The ADRC of Oregon website has been created and maintained with resources available to our region. This site is shared with anyone who contacts our office with questions.

Appendix E: Emergency Preparedness Plan

Emergency Preparedness Plan for Senior and Disability Services

As a Council of Governments, we are in the process of drafting an agency-wide Continuity of Operations and Emergency Protocols Manual, *COOP*, (attached).

In 2009, our management team invited the Red Cross to provide our staff training in Linn and Benton Counties. The Red Cross provided everyone with a bucket of the critical items each person and family would need in an emergency. The training helped prepare our staff for an emergnecy if they are at home. As a part of the training we asked them to consider how they could respond as a member of our staff serving seniors and people with disabilitiesin the event of an emergency.

Senior and Disability Services is the go-to agency for some of the most vulnerable adults in our region. Because of this, our staff actively serves on the Linn Benton Vulnerable Poulations Planning Committee, and has for nearly five years. The committee consists of partner agencies, emergency response teams (law enforcement, fire), consumers, Samaritan Health Services, and other city and county representatives. This committee has also drafted an area-wide emergency plan in order to prioritize and meet the special needs of the most vulnerable adults in the area (Linn Benton Vulnerable Populations Emergency Plan attached).

Every local nursing facility and assited living facility is noted on an emergency response priority list and "map" by the Linn Benton Vulnerable Populations Planning Committee. The adult foster care homes are also listed and given high priority as they are smaller, private homes, often without back up generators or located in rural areas.

The OCWCOG COOP directs the managers to have a complete cell phone list of the management team and their line staff. If the Program Director determines an emergency alert is in effect, managers who can travel to the office or a designated location, will do so.

The COOP also dictates that the public will be alerted if the office is open or not, and we will begin the communication process between partner agencies and emergency response teams. Communication will be via FlashAlert News Wire, which notifies all television, radio stations, and newspapers within the CWCOG service areas. The HR Manager, in coordination with appropriate Department Director will be responsible for posting information on FlashAlert News Wire.

Clients/Consumers

We have compiled a list of the most vulnerable SDS clients which is updated quarterly by program supervisors in all three counties. The list is generated from the client assessment tool (CAPS) in the risk assessment portion that is updated by Case Managers annually. The risk assessment requires case management staff to monitor those at high risk monthly. Although there is priority given to in-home clients in an emergency, risks are weighted by need for medications, oxygen, rural locations, availability of caregivers, and the overall physical and cognitive limitations of the clients. Some clients may live with relative caregivers, but still be at a high risk in the event of an emergency given their location and/or need for medical assistance.

This emergency list is distributed to each of SDS manager in a sealed envelope to open only in the case of an emergency each quarter. The lists are kept with the managers in the event they need them when the office is closed. Copies are also kept in a safe at each office location and local emergency response teams would have access to the lists in the event of an emergency. Our management team has also established contact-responsibility with local emergency response teams based on our proximity in Linn, Benton and Lincoln counties. All fire, city police and sheriff offices will have a contact by one of the eight SDS managers as needed. In Lincoln County, there is an agreement with the Newport DHS office that in case of an emergency, our staff can co-locate to work and contact clients in the community.

Dependent on the type of emergency or disaster, client lists would be used to:

- Notify emergency response teams of those at highest risk if stranded for more than three days;
- Contact clients, families, and/or caregivers (if able) to check on their status and evaluate needs;
- Contact clients, families, and/or caregivers after the emergency has subsided to evaluate their status and needs.

Continuity of Operations (COOP)

and

Emergency Protocols

Updated: 8/2012

Oregon Cascades West Council of Governments
1400 Queen Ave., SE
Albany, OR 97322

Introduction

This document contains the Business Continuity Plan for Oregon Cascades West Council of Governments (OCWCOG). It is the document containing the information needed to post-interruption decision-making and the agency's response to any disruptive or extended interruption of the organization's normal operations and services. This plan outlines an action plan appropriate for our clients, employees, and visitors in the event of an emergency. This plan identifies natural and man-made emergencies that may impact our operations as well as the community. It details the response procedures that should be followed in case of an emergency.

Purpose

The CWCOG Business Continuity Plan is to be used as a guide whenever an event results in prolonged disruption of business at any of our OCWCOG worksites. Some examples of events that may cause a disruption of business are:

- Fire or other damage to the building
- Natural disasters such as earthquakes, flood or volcano
- Chemical Event
- Temporary loss of significant number of staff
- Damage or interruption to utilities, computer or telephone systems

Applicability and Scope

This Plan is based on a short-term (less than five business days) closure. If closure is for an extended period of time, all functions will resume operation as quickly as possible at a new and previously identified temporary long term location.

A copy of this Plan is to be maintained by all OCWCOG managers and at each worksite. A backup copy of this Plan will be kept offsite by the Executive Director, the Human Resources Manager, and the Program Directors.

All OCWCOG employees have received a copy of the OCWCOG Employee Office Safety and Protection Guide. This guide is to assist employees in dealing

with the emergency at-hand and the safety of building occupants. If the building cannot be used, the OCWCOG Business Continuity Plan will be used.

The succession of events in an emergency are not predictable, hence, published support of operational plans will serve only as a guide and checklist, and will require modification during an event to meet the requirements of the emergency. Flexibility and rationality are keys to successfully managing and emergency. Our organization stresses human safety above material loss at all times.

The following people have been designation as the OCWCOG Continuity Planning Team.

Continuity Planning Team	
Mary Kay Fitzmorris	Toledo
Teresa Conley	Corvallis
Lydia George	Albany
Randy Moore	Albany
Brenda Mainord	Albany

Guiding Principles and Assumptions

- Every incident will be different, both in severity and in length of impact. The response needs to be flexible and meet the needs of the incident.
- Safety of staff and clients is the first goal, though efforts will be made to minimize damage to property.
- Responses will be made in cooperation with local emergency authorities and organizations according to the Linn-Benton Vulnerable Populations Emergency Plan. Assistance will be available from outside our tri-county area through mutual aid agreements with County, State and Federal emergency services.

- Documentation of the event and all steps taken, decisions made, and funds expended are very important.
- Every event is stressful on all employees. If the response is likely to last more than a couple of days, plans should be made to rotate staff to allow for periods of rest.
- A major disaster event will likely affect the lives of many Linn, Benton and Lincoln County agency employees limiting, or preventing, them from performing shelter and care activities.
- A major disaster will likely result in loss of utilities, communication systems, and transportation systems making evacuation to mass care facilities difficult and may limit which mass care facilities can be used.
- Experince has shown that a high percentage of evacuees will seek lodging from friends or relatives rather than go to facilities during minor events or localized conditions.
- Additional services, including the care of special needs groups and crisis counceling, will be required from our agency.
- Many residents, especially those with special medical needs, may asssume there will be local resources available to rescue them. Medically-fragile clinets may not have access or transporation to regular services such as dialysis, oxygen or chemotherapy.
- Patients who normally receive home helathcare services may need to be accompanied by a caregiver to a shelter. In such cases, the caregiver should be transferred with the evacuee and permitted to remain with that person as the caregiver is able.

SECTION

1

Activation of Plan

Decision Process

The Executive Director, or successor if the Executive Director is not available, will make the decision whether or not to implement the COOP. Communication of decisions will flow from the Executive Director to the Program Directors. Program Directors will be responsible for communicating to their unit Managers or designated staff and on down to their assigned staff. Section 2 of this Plan further describes the agency communication protocol.

Orders of Succession

Succession for the Agency will take place in the event the Executive Director is unavailable, debilitated, or incapable of performing their legally authorized duties, roles, and responsibilities.

Successors
Scott Bond, Senior and Disability Services Director
Alison Covey, Finance Director
Steve Martinenko, Technology Services Director

Succession of each Department for the purpose of continuing operations is as follows:

PROGRAM	PRIMARY STAFF PERSON	FIRST BACK UP PERSON	SECOND BACK UP PERSON
Senior & Disability Service	**Scott Bond**	Gale Blasquez	Randi Moore
CED	**Cynthia Solie**	Phil Warnock	Brenda Mainord
Tech Services	**Steve Martinenko**	Troy Grover	Third Party Vendor
Human Resources	**Lydia George**	Finance Director	Diana Crumpton
Finance	**Alison Covey**	Cynthia Solie	CWCOG Board Treasurer

Each Program Director will also have a succession plan for each office. The Program Directors will communicate this plan with their Unit Management Team.

Employees are encouraged to have individual and family emergency plans. Being prepared themselves will keep them better equipped to help others in the event of an emergency. It is recommended to keep a five day kit, stocked with food, water, blankets and other supplies.

SECTION

2

Communications

Oregon Cascades West Council of Governments is registered with the Linn-Benton ALERT Emergency Notification System and with the Reverse 9-1-1 alert system in Lincoln County. If an event has been reported, the Executive Director will contact the appropriate county's Emergency Management program through the Sheriff's office to verify. A list of Emergency Resources can be found in the Appendices of this document.

Once the event has been verified, the following communications plan will be used:

Employees

During an event, we will assess which means of communication are still available to us, and use the means closest in speed and form to the means that we have used in the past to communicate with the staff.

All OCWCOG managers, including the Facilities Maintenance Coordinator and the Network Operations Specialist, are required to maintain a cell phone for emergency contact purposes. Human Resources provides an updated emergency after-hours contact list to each person required to maintain a cell phone.

The Human Resources Manager will also provide an updated employee contact list to unit managers on a monthly basis.

Communication decisions will flow from the Executive Director to the Program Directors. Program Directors will be responsible for communicating to their unit Managers or designated staff and on down to their assigned staff.

The Senior and Disability Services Program Director will serve as the Public Relations Officer at an emergency scene. Only the Public Relations Officer (or a representative designated by the Director) will provide statement to media personnel. Not all employees will have all of the pertinent information; therefore, employees will be instructed not to release any information to media personnel,

and to provide “no comment” when approached for information by any member of the media.

The on-site Supervisors have been designated as Building Evacuation Supervisors. The Evacuation Supervisors will assist employees as needed during an evacuation, and will take a head count of all employees in the building at the time.

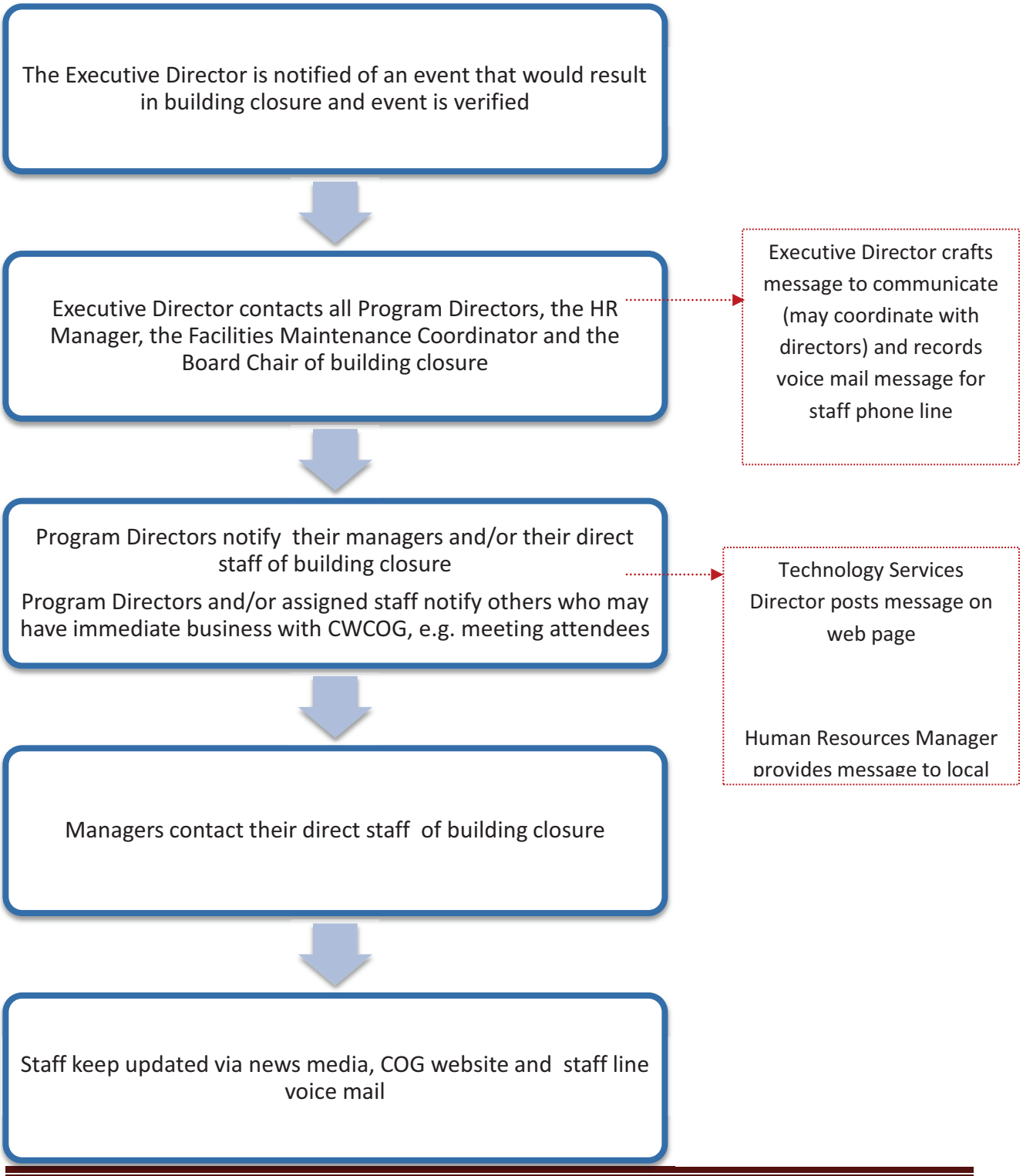
External internet based communications will be posted by HR or Technology Services staff. OCWCOG is registered with FlashAlert News Wire, which notifies all television, radio stations, and newspapers within the Albany/Corvallis, Eugene/Roseburg, and Portland/Salem (includes Lincoln City and Newport) of any business continuity information that needs to be communicated to OCWCOG employees. The HR Manager is responsible for providing the necessary information to FlashAlert News Wire. If the HR Manager is not available, another assigned OCWCOG Continuity Planning Team member will contact FlashAlert.

If phone service to the affected worksite has not been obstructed, voicemail instructions will be recorded on the following Staff Information Lines:

Albany/Corvallis Staff Line	**541-924-8434**
	1-888-777-5960
Toledo Staff Line	**541-336-2289**
	1-800-354-1095

If an event should result in a building closure, the following chart illustrates the agency flow of communication.

Agency Flow of Communication



Communications to OCWCOG clients/customers and other people we do business with is as follows:

Clients/Customers

In the event that any of the OCWCOG buildings are closed to the public, information will be posted on the external website by HR or Technology Services staff. Information will also be communicated to the public via FlashAlert News Wire, which notifies all television, radio stations, and newspapers within the OCWCOG service areas. The HR Manager, in coordination with appropriate department Directors will be responsible for posting information on FlashAlert News Wire.

If feasible, information and instructions for our consumers will be posted by the OCWCOG Primary Responders on the outside doors of each affected worksite.

Shared Resource Organizations

In the event that any of the OCWCOG buildings are closed to the public and/or business services suffer interruption, other agencies should be notified and kept informed. The appropriate Program Directors, or assigned staff, will be responsible for communicating the status of OCWCOG operations with them. Shared resource organizations are found in the Appendices of this document.

SECTION

3

Disaster Detection and Determination

Should there be an event that would potentially cause any of the COG buildings to be inaccessible, a primary responder will be responsible for assessing the building and reporting to the Executive Director. Designated Primary Responders are as follows:

Albany Building: **Facilities Maintenance Coordinator** and/or assigned back-up

Toledo Building: **Senior & Disability Services Program Manager** and/or assigned back-up

Corvallis Building: **Senior and Disability Services Director** and/or assigned back-up

Each Primary Responder will have an assigned backup should they be unavailable to assess their assigned building.

Each building has a Vendor Reference Manual that will provide contact information of building contractors. A list of primary vendor contacts is provided in the Appendices of this document.

Should an event happen that could potentially compromise any of the OCWCOG facilities, the Executive Director will verify the event and then contact the appropriate Primary Responder for that building. The Primary Responder will assess the building using an assessment check-off list to determine damage and/or safety concerns and report back to the Executive Director.

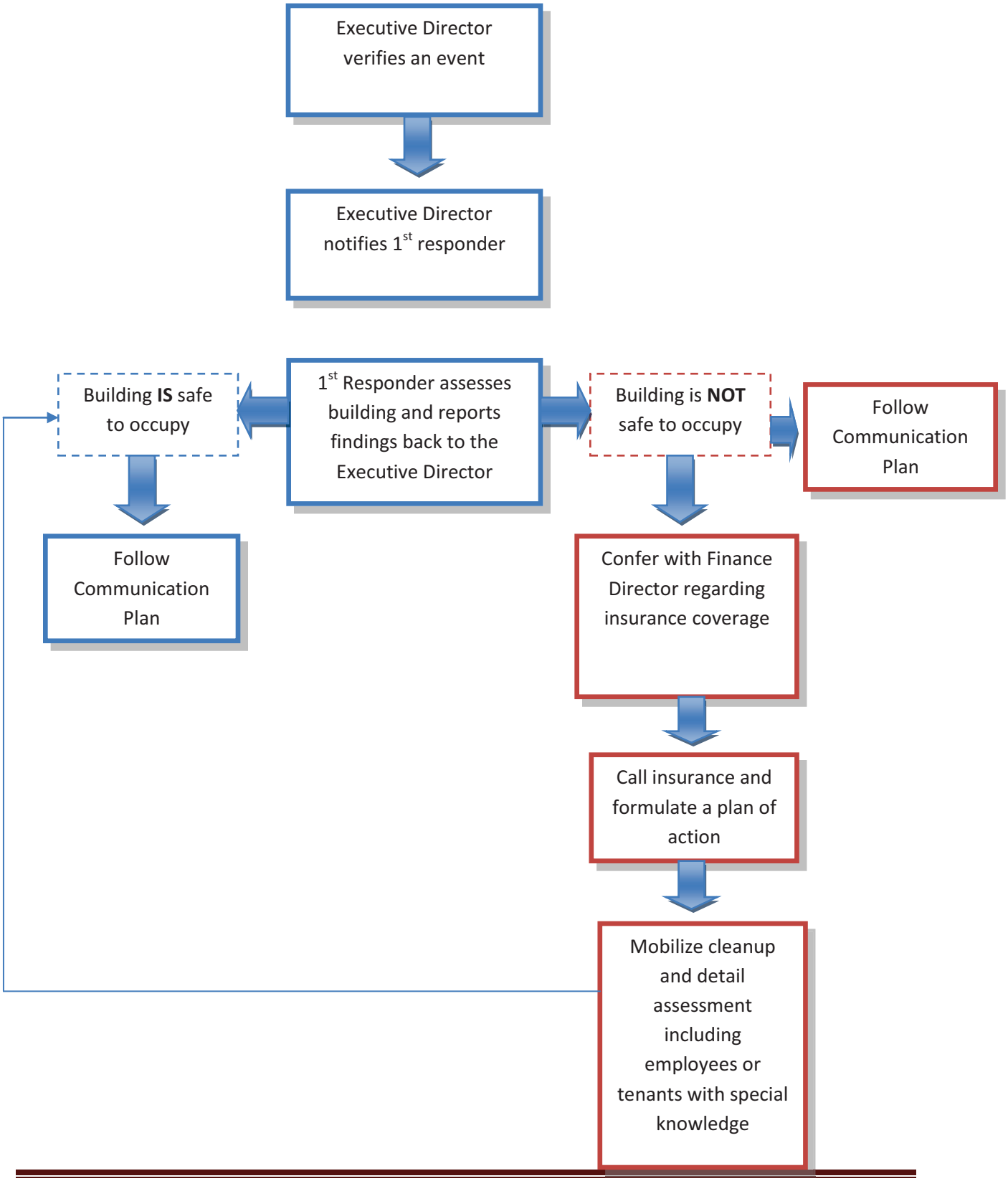
If the building is found safe to occupy, staff will follow the Communication Plan outlined in Section 1 of this manual.

If the building is not safe to occupy, staff and tenants will be notified per the Communication Plan. The Primary Responder and/or the Facilities Maintenance Coordinator will confer with the Finance Director regarding insurance coverage. The Facilities Maintenance Coordinator will contact the insurance company to formulate a plan of action to mobilize cleanup and detail. A copy of City County

Insurance Services' Claim Procedure can be found in the Appendices of this document. The Facilities Maintenance Coordinator will notify the appropriate vendors, and employees and building tenants who have the expertise needed to regain building operations.

The following flow chart illustrates detection and determination.

DISASTER DETECTION AND DETERMINATION FLOW CHART



Types of Hazards

Electrial Fire Hazards

Electrical system failures and the misuse of electrical equipment are the leading causes of workplace fires. Fires can result from loose ground connections, wiring with frayed insulation, or overloaded fuses, circuits, motors or outlets.

To prevent electrical fires, employees should:

- Replace worn wires.
- Use appropriately rated fuses.
- Do not use extension cords as substitue for wiring improvements.
- Use only aproved esxtension cords.
- Check wiring in hazardous locations where the risk of fire is especially high.
- Check electrical equiptment to ensure it is properly grounded or double insulated.
- Ensure adequate spacing while performing maintenance.
- Do not overload curcuits with office equiptment.
- Turn off nonessential electrical equiptment at the end of each workday.
- Keep storage areas and walkways clear.
- Do not let trash and recycling accumulate.

General Fire Prevention and Procedures

Fire prevention is everyone's responsibility. Unsafe practices shall not be tolerated. The following safe practices are required of all staff members.

- Flammables and Combustibles will not be stored near heaters, electrical appliances or other potential sources of ignition.

- Smoking is prohibited in public places and places of employent, which means smoking is prohibited in all OCWCOG buidings and within ten feet of a service line that extends out of doors.
- Do not block potential escape routes.
- Any gasoline, kerosene or cleaning solvents which must be stored inside, must be stored in an approved container with identifying information readily visible.

Administrators shall present basic fire prevention training to all employees upon employment, and shall maintain documetation of the training. Portable extinguishers shall be maintained in fully charged and operable condition. Maintenance staff will provide upkeep of fire alarms and sprinkler systems throughout our facilites. All persons in their respective buildings need to know how to get out of the building in the event of a fire or other emergency. Fire exits should be clearly marked, identifiable and continually up kept by maintenance staff. In the event of an emergency, stairs should be used as preference to elevators.

Medical Emergencies

Major mecial emergencies can include an array of conditions such as a fall, burns, choking, heart attack, poisoning, severe bleeding or stroke.

How to respond:

- Quickly assess emergency situation.
- Check for any additional immediate danger.
- Seek professional medical help as soon as possible.
- Avoid moving an injured person unless absolutely necessary.
- Wait until medical help arrives.
- Do not provide first aid or CPR unless you have been trained.

Natural Disasters

Hurricane

High winds, flooding and flying debris resulting from hurricanes can be extremely dangerous. Hurricanes typically affect coastal areas such as Lincoln County, but can also inflict damage far inland. A hurricane watch is issued when threat hurricane conditions are expected within 24-36 hours. A hurricane warning is issued when hurricane conditions are expected within 24 hours or less. The hurricane season lasts from July through November.

How to Respond:

1. It is essential that all employees stay indoors throughout the entire hurricane. During the peak of the storm for maximun protection, it is suggested that employees close doors and remain In hallways and/or spaces farthest from windows.
2. Employees should remain away from dangerous areas, such as glass windows.
3. Do not attempt to open windows or doors to see what is happening outside.
4. Employees should report all accidents, inuuries, broken windows, or excessive water to a supervisor.
5. Telephone calls should be made only in case of emergency.
6. Keep in mind that everything is calm when the eye of the strom passes overhead. Do not venture outside, as the second half of the storm will follow shortly.
7. Do not use fire stairs to go to an adjacent floor where the elevator will be shut off. Do not go outside.

Tsunami

A tsunami can cause major damage and loss of life along coastal areas, such as Lincoln County. Traveling at speeds of up to 500 miles per hour, a tsunami wave can be among the most powerful destructive forces on Earth. These waves typically occur as a result of earthquakes giving little or no warning for nearby shorelines.

How to Respond:

1. Listen to broadcasts that keep citizens up to date of potential tsunami situations. National Oceanic and Atmospheric Administration weather radios are especailly helpful in sending out immediate warnings and instructions. Local news stations are typically quick to respond and get the message out to the people in their listening area.
2. Listen carefully to instructions and follow them in order to remain as safe as possible until the all clear has been issued for your area.
3. Move away from the shoreline and seek higher ground and stay there. Tsunamis are not a single wave, but are instead a series of waves that are unpredictable. Do not return to low ground until the all clear signal has been given.

Earthquake

One of the most destructive phenomena of nature is an earthquake. An earthquake is a sudden, rapid shaking of the Earth, caused by the breaking and shifting of subterranean rock as it relases strain that has accumulated over a long period. This is followed by aftershocks.

How to Respond:

1. React quickly, but stay calm.
2. Move away from windows. Duck and cover or stand securely in a doorway to avoid falling debris.
3. Do not use elevators or stairs until identified as safe.
4. Expect fire alarms and sprinklers to activate.

Flood

Floods are the most common hazard for our tri-county area. Flooding can happen gradually or in an instant. Flash floods usually occur within a few minutes or hours of excessive rainfall or sudden rush of water held by an ice jam. Flash floods often have a dangerous wall of roaring water carrying rocks, mud and other debris.

Overland flooding, the most common type of flooding, typically occurs when waterways such as rivers or streams overflow their banks as a result of rainwater. It can also occur when rainfall or snowmelt exceeds the capacity of underground pipes, or the capacity of streets and drains designed to carry flood water away from urban areas.

How to Respond:

1. Turn off main switches or valves if instructed to do so. Disconnect electrical appliances. Do not touch electrical equipment if you are wet or standing in water.

2. Keep a safe distance from flooded water. Avoid walking through moving water. Any amount of flooded water can cause a fall. If you have to walk through water, walk where the water is not moving. Use a stick to check the firmness of the ground in front of you.

3. Do not drive into flooded areas. If floodwaters rise around your car, abandon the car and move to higher ground if you can do so safely. You and the vehicle can be swept away quickly.

4. Do not camp or park your vehicle along streams, rivers, or creeks, particularly during threatening conditions.

Severe Winter Storm

A winder storm watch means severe weather is possible. A winter storm warning signals that severe winter weather is expected. A blizzrd warning signals severe weather with substantial winds is expected. A Travelor's Advisory means that conditions may make driving unsafe. In some instances during extreme weather or other emergency conditions OCWCOG may close operations. SDS will notify employees if evacuation is necessary.

Bomb Threat

Anyone who recieves a bomb threat should adhere to the following procedures in the order shown.

1. The person receiving the threat should remain calm and attempt to obtain as much information as possible from the caller.
2. Call 911. Give your name, location and telephone number. Inform the responder of the situation, reporting the exact words of the threat including information you may have as to the location of the threat, time of the threat and time you received the call. Emergency personnel will handle the evacuation if necessary upon their arrival.
3. Do not evacuate the building and do not sound the alarm, but wait for further instruction. Authorities will be responsible for necessary evacuation of buildings.
4. If you should spot something our of the normal that appears suspicious, report it to your supervisor. Under no circumstances should you touch, tamper with, or move objects that look out of place or confront persons acting suspicious.
5. Immedicately cease the use of all wireless transmission equipment.
6. Record conversation if at all possible.
7. If the buiding is evacuated, move as far from the building as possible.
8. Keep the street, fire landings, hydrants and walkways clear to emergency vehicles and crews.
9. Do not return to the building until told to do so by emergency personell.

SECTION

4

Essential functions

Essential functions are those organizational functions and activities that must be continued under any and all circumstances.

OCWCOG has identified the following functions as essential and are those that cannot suffer interruption for more than 12 hours.

Priority	Essential Functions
1	Telecommunications/Voice Mail
2	Computer and Remote Access
3	In-home client health and safety check
4	Medical transportation through RideLine
5	Adult Protective Services

Each program has established protocols for emergency situations.

Technology Services

In the event the network has been compromised, the following protocol will be used in order to retain network services as quickly as possible:

- If the Albany building is not accessible, Technology personnel are to report to the Corvallis office in order to carry out their assigned functions to get the network operational.
- Should the Corvallis office also be inaccessible, the Technology Services Director will contact the Philomath Police Department in order to set up an offsite office. The Network Operations Specialist will report to the Toledo office.

- The first priority for Technology Services is to establish phone communications followed by remote access to the agency network through an operational office. Secondary tasks will involve restoring agency data and critical services such as the Transportation Brokerage, Springbrook, and Oregon Access.
- Photos of the server room equipment and its location are included as a part of this Plan. Should emergency personnel be able to access the building, the Technology Services Director, or designee, will remove critical equipment, such as hard drives and backup tapes, if feasible.
- The State Department of Human Services (DHS) will be contacted to allow staff to access Oregon Access and other State programs from alternate locations.

A list of pertinent Technology Services Vendor information is provided in the Appendices of this document.

Telephones/Voice Mail

All phone and fax lines can be forwarded to locations where a telephone line exists. This includes forwarding to cell phone numbers. Phone lines can be forwarded immediately through an Internet control interface that Technology Services staff has access to or by calling the phone provider. In the event the Internet is no functioning and a phone provider has to be called, expect up to 72 hours before the forwarding takes effect, although the published agency numbers can typically be forwarded within 4 hours. The published numbers are:

Albany: 541-967-8720 (GA), 541-967-8630 (SDS), 541-967-8551 (CED)

Corvallis: 541-758-1595

Toledo: 541-336-2289

In addition, toll-free numbers can be forwarded to different phone numbers by calling the phone provider. Agency voicemail is provided by one server located in the Albany office. In the event this server is inoperable, the phone provider can provide voicemail service on the published phone lines within 72 hours.

Computer and Remote Access

The majority of the OCWCOG management team has been set up through Technology Services with remote access to the agency network. In the event the building(s) is not accessible, and the network has not been compromised, the Program Directors and Managers with remote access, can access emails and critical files and information stored on the network from their home or another location.

Computer connectivity priorities have been established as follows:

Priority	Program
1	OBBS (Brokerage)
2	Senior and Disability Services
3	ADRC
4	Veteran's Services
5	General Administration
6	LMS (Lending)

In-Home Client Health and Safety Check

A list of the most vulnerable of OCWCOG's clients in updated quarterly. This list consists of individuals who will not be able to function without aid during an emergency. This list is distributed to each of OCWCOG's managers in a sealed envelope to open only in the case of an emergency. Copies are also kept in a safe at each office location.

Senior Meals

Meal Sites are equipped with non-perishable foods for use when adverse weather or other emergencies prevent timely delivery of hot meals.

Meals on Wheels recipients are provided with emergency meal boxes stocked with non-perishable foods. These are to be used in the event of an emergency if volunteers can not safely deliver hot meals.

SECTION

5

VITAL RECORDS MANAGEMENT

Critical records of the agency have been identified in order for the continuation of business. Records required for business success, legal reasons, regulatory agency, and/or to support recovery efforts are listed to the extent possible. How records are stored and how they may be accessed are as follows:

Federal Records

Vital File, Record or Database	Form of Record (e.g., hardcopy, electronic)	Pre-positioned at Alternate Location	Hand Carried to Alternate Location	Backed up at Third Location
Program Management				
Receipt of Fed Funds				
Federal Grants	Electronic	Feds		
CFDA Numbers	Electronic			
SBA Loans		CWFS		
USDA/RDF 133&4				
EDA/RLF		LMS & Auditors		
EEOC Reports	Electronic	Department of Labor		
I-9's	Hard copy			

Emergency Operations Records

Vital File, Record or Database	Form of Record (e.g., hardcopy, electronic)	Pre-positioned at Alternate Location	Hand Carried to Alternate Location	Backed up at Third Location
Emergency Continuity of Operations Plan (COOP)	Hard copy and electronic	All Program Directors		
Staff contact and assignment information	Hard copy and electronic	Program Directors and Management Team		X
Orders of succession and delegations of authority	Hard copy and electronic	Included in COOP		
Agency Insurance Information	Hard copy	Barker Uhrlings & CIS		
Policy, procedural and systems manuals	Hard copy and electronic			
List of credit card holders to purchase needed supplies	Electronic	US Bank		

Rights and Interest Records

Vital File, Record or Database	Form of Record (e.g., hardcopy, electronic)	Pre-positioned at Alternate Location	Hand Carried to Alternate Location	Backed up at Third Location
Agency Bylaws	Hard copy & electronic			
Articles of Agreement	Hard copy and electronic			
Articles of Incorporation	Hard copy in fire proof file cabinet			
Board Resolutions	Electronic			
State & Federal Employer Identification Number Authorization	Hard copy in fireproof safe			
Audit Reports	Hard copy and DVD in fire proof safe			
Adopted Budgets	Electronic			
Payroll and Accounts Receivable	Electronic	Springbrook		
Personnel Files	Hard Copies			
Client Records	Electronic	State of Oregon DHS		
COG Inventory	Electronic			
Titles, deeds, and contracts	Hard copies in fire proof safe			

SECTION

6

COOP Planning Responsibilities

All OCWCOG managers are designated as Emergency Relocation Team (ERT) personnel. The team members are responsible for ensuring that the elements of this Plan are activated and followed by providing leadership in a calm manner to enable the continuation of mission critical functions.

OCWCOG recognizes the importance of taking care of family first in order to be available to then serve the agency. Employees must be sure that their family is safe and secure prior to reporting to work. Employees should develop a personal "go kit" that includes the items their families will need if they have to evacuate or shelter in place. As well, employees should have an office "go kit" that includes the employee's contact information.

The following table reflects COOP responsibilities for the agency:

Responsibility	Position
Update COOP plan annually.	Executive Director, Program Directors, and HR Manager
Update telephone rosters monthly.	HR Manager
Review status of vital files, records, and databases.	Finance Director, Technology Services Director, other Program Directors as appropriate
Conduct alert and notification tests.	HR Manager in coordination with the Program Directors
Develop and lead COOP training.	HR Manager
Plan COOP exercises.	HR Manager in coordination with the Program Directors

SECTION

7

Test, Training, and Exercises

Training will be provided to all OCWCOG managers, and key personnel, in order to ensure consistent application of the Plan, when a crisis occurs, for continuity of operations.

- The Continuity Planning Team and key personnel will test the Plan to confirm whether or not procedures, processes, and systems function as intended.
- Managers will train their staff to ensure that all personnel know what to do, how to do it, and when it should be done during an emergency.

Designated managers will complete an After-Action Report regarding any emergency incidents. The Continuity Planning Team will review and analyze the data from the After-Action Reports to determine if there are any areas of improvement needed for the OCWCOG Business Continuity Plan.

COOP Plan Maintenance

Our Continuity Planning Team will meet annually to review this document, Continuity of Operations and Emergency Protocol, for necessary updates and revisions. Key evacuation routes, roster and telephone information, as well as maps and room/building designations of alternate locations will be updated as changes occur.

EMERGENCY RESOURCES

Linn and Benton County

AGENCY	PHONE
Linn Co. Sheriff *Emergency Management*	**541-967-3901**
Benton C. Sheriff *Emergency Management*	**541-766-6864**
Linn County Public Health *Albany* *Lebanon* *Sweet Home*	 **541-967-3888** **541-451-5932** **541-367-3888**
American Red Cross	**541-926-1543**

Lincoln County

AGENCY	CONTACT PERSON
Lincoln Co. Sheriff *Emergency Management*	**541-265-0651**
American Red Cross	**541-265-7182**
Reverse 9-1-1	**9-1-1**

State of Oregon

AGENCY	CONTACT PERSON
DHS Public Health Division	971-673-1222

Radio Stations

STATION	PHONE NUMBER	CITY	RADIO DIAL
KRKT	**541-917-0212 early am** **541-926-8628 office** FAX 541-928-1261	Albany	990AM/1240AM 1340AM 106.3FM/99.9FM
KSHO KGAL	**541-926-8683** FAX 541-451-5429	Albany	920AM 1580AM
KHPE KWIL	**541-926-2431** FAX 541-926-3925	Albany	107.9FM 790AM
KLCC	**800-922-3682** **541-463-6000**	Eugene	89.7FM
KBCH	**541-994-2181**	Lincoln City	1400 AM
KNPT KYTE	**541-265-2266**	South Lincoln Co.	1310 AM 102.7 FM
KFIR	**541-367-5115**–Steve (after 4:30am)	Sweet Home	720 AM
KORC	**541-563-5100** FAX 541-563-5116 Email: bet8@korcam820.com	Waldport	820 AM

Linn-Benton Vulnerable Populations Emergency Plan

An Annex

County Emergency Operations Plans

June 2012

Linn County

Benton County

Records of Revisions

Revision to the Emergency Operations Plan (EOP) Vulnerable Populations Plan will occur based on the following:

- Changes to the County Emergency Operations Plan
- As a consequence of the lessons learned from events or exercises
- As a consequence of new federal, state, or local guidelines and mandates

Revision Number	Date of Revision	Text Revised	Individual Initiating Revision
1	June 2012	Plan Created	A. Vendetti
2	7/13/2012	8.1.2 & 8.1.3 Edited	A. Cornell
3	7/17/2012	Plan-wide Edits	J. Fleischbein
4	7/19/2012	Plan-wide Edits	A. Vendetti

Purpose

The Linn-Benton Counties Vulnerable Population Plan addresses specific emergency assistance and additional needs that members of vulnerable populations in the counties may have before, during, and after an incident.

This plan addresses specific requirements for vulnerable populations in the areas of transportation, mass care, emergency assistance and human services that are generally addressed in Emergency Support Function #1 – Transportation, Emergency Support Function #6 – Mass Care, Emergency Assistance, Housing, and Human Services, and ESF # 8 – Public Health and Medical Services found in each of the county's Emergency Operations Plans.

In addition to information in the Linn and Benton County Emergency Operations Plans, this plan also identifies:

- Resources that may be needed for the special needs population during an emergency
- Available support services within the community.
- Possible sources of alternate services and resources if the need is greater than the availability
- Alternate methods to communicate emergency information to people with disabilities, limited English proficiency, and to members of diverse cultures.

Definitions

This plan identifies and defines the following four terms:

- Vulnerable populations
- Special needs populations
- Special medical needs populations
- At-risk populations

The term "vulnerable populations" will be used primarily throughout this document; however, other terms will be referred to as appropriate. The definitional framework for special needs populations allows planners to plan for a predictable and specific set of functional support needs. This framework also establishes parameters for resource allocation. This definition satisfies a key recommendation from the U.S. Department of Homeland Security (DHS) Nationwide Plan Review, which calls on the federal government to develop a consistent definition of the term "special needs."

Vulnerable Populations

According to the National Association of County and City Health Officials (NACCHO), vulnerable populations are defined as, *"a range of residents who may not be able to comfortably or safely access and use the standard resources offered in disaster preparedness, relief, and recovery."* Addressing the specific needs of these populations may require detailed planning. Vulnerable populations may include, but are not limited to, people with or those who are:

- Sensory impairments (blind, deaf, hard-of-hearing)
- Cognitive disorders
- Mobility limitations
- Limited English comprehension or non-English speaking
- Elderly
- Geographically or culturally isolated
- Medically or chemically dependent
- Homeless

Special Needs Populations

Special needs populations can be described as a subset of vulnerable populations. The National Response Framework (NRF) defines special needs populations as *"populations whose members may have additional needs before, during, and after an incident,"* including but not limited to:

Transportation

Includes individuals who cannot drive due to a particular disability or who do not have a vehicle and will require transportation support for successful evacuation. Support may include but is not limited to:

- Making accessible vehicles available (e.g., lift and/or ramp equipped or vehicles suitable for transporting individuals who use oxygen)
- Providing information on how/where to access mass transportation in the event of an evacuation

Communication

Includes individuals who have limitations that interfere with the receipt of and response to information. These individuals will need to receive information in methods they can understand and use. Certain communication limitations may hinder or prevent them from performing particular actions, including but not limited to the following:

- Hearing verbal announcements
- Seeing directional signage
- Understanding how to get assistance due to hearing, vision, speech, cognitive, or intellectual limitations, or limited English proficiency

Medical Care

Includes individuals who require assistance and are not self-sufficient or do not have adequate support from caregivers, family, or friends. These individuals require the support of trained medical professionals. Assistance may include but is not limited to:

- Managing unstable, terminal, or contagious conditions that require observation and ongoing treatment
- Managing intravenous (IV) therapy, tube feeding, and vital signs
- Accessing dialysis, oxygen, and suction administration
- Managing wounds
- Operating power-dependent equipment to sustain life

Supervisor
Before, during, and after an incident, some individuals may lose the support of caregivers, family, or friends or may be unable to cope in a new environment. Certain individuals, that may have particular conditions, will require supervision to make decisions affecting their welfare. These individuals include, but are not limited to, the following:

- Those with dementia
- Those with Alzheimer's disease
- Those with psychiatric conditions (e.g., schizophrenia or depression)
- Unaccompanied children
- The elderly

Maintaining Independence
Individuals in need of support that enables them to be independent in daily activities may lose this support during an emergency or disaster. By supplying needed support/devices, the County can assist individuals in better maintaining their independence. Support resources may include:

- Lost or damaged durable medical equipment (e.g., wheelchairs, walkers, scooters, catheters, ostomy supplies, etc.)

The NRF definition of special needs provides a function-based approach for planning and seeks to establish a flexible framework that addresses a broad set of common function-based needs, irrespective of specific diagnosis, statuses, or labels (e.g., children, the elderly, transportation disadvantaged). This function-based definition reflects the capabilities of the individual, not the condition or label. Resources available in Linn and Benton Counties, along with planning considerations based on specific factors and associated functional needs of those with special needs, are addressed in Appendix B, Resource Matrix.

Individuals in need of additional response assistance may include those who:

- Have disabilities
- Live in institutionalized settings
- Are elderly
- Are children
- Are geographically/culturally isolated
- Have limited English proficiency
- Are non-English speaking
- Are without regular and/or adequate transportation

Special Medical Needs Populations
Special medical needs populations are a subset of the special needs populations. According to the U.S. Department of Health and Human Services (HHS), special medical needs populations are defined as *"those individuals, typically living in the community and outside of a medical setting or environment, who need support to maintain an adequate level of health and independence during times of emergency."* Included in this category are individuals who, before, during, and after an emergency, are:

Medically dependent on uninterrupted electricity for therapies

Require continual or intermittent medical care/support from a healthcare professional

Are not self-sufficient with the loss of usual support from caregivers

At-risk Populations

HHS defines at-risk individuals as those who, before, during, and after an incident, "may have additional needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation." In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional response assistance include those who have disabilities; live in institutionalized settings; are geographically/culturally isolated; have limited English proficiency or are non-English speakers; are without regular and/or adequate transportation; have chronic medical disorders; and have a pharmacological dependency.

The difference between the HHS definition and the NRF definition of special needs is that the NRF definition does not include the following:

- Pregnant women
- Those who have chronic medical disorders
- Those who have a pharmacological dependency

The HHS definition includes these three other groups because pregnant women are specifically designated as at-risk in the Pandemic and All-Hazards Preparedness Act and those who have chronic medical disorders or pharmacological dependencies are two other populations that HHS has a specific mandate to serve.

Situation

Linn and Benton Counties are set in the Willamette Valley. The counties are susceptible to the impacts of disasters, both natural (snow, wind, earthquakes, floods, wildfires, etc.) and manmade (hazardous materials, transportation, technological). Due to the large diversity in the population for the counties, it is important to plan for individuals who may not be able to easily act or understand directions given in the time of a disaster. More information can be found in each county's Hazard Vulnerability Assessment.

Vulnerable populations make up a large percentage of a community's population. Because of this large population it is important to plan on how officials and responders will reach out to these groups as well as how to best help them recover. Working with the community is important when planning for the vulnerable populations to utilize the wealth of knowledge, experience, and resources the community offers.

According to the 2010 Census Linn and Benton counties have a combined population of about 200,000 people. This population can be affected by a number of potential disasters. According to the American

Community Survey (ACS) 5-year average for 2006-2011, over 20 percent of the population of the 2 counties has a disability. Some of these individuals may be self-sufficient, while other may need assistance completing tasks on a daily basis.

Young children, seniors and people with limited income also comprise significant vulnerable populations within Linn and Benton counties. Geographic/cultural isolation, limited access to motor vehicles, limited income, difficulty communicating and understanding English, extreme age, and limited income are also situations that can leave an individual more vulnerable in a disaster.

- Linn County
    - Disabled: 22.02%
    - Under 5 Years Old: 6.83%
    - Over 65 Years Old: 14.92%
    - Limited Income (Under 100% of the poverty level): 16.27%
- Benton County
    - Disabled: 13.06%
    - Under 5 Years Old: 4.38%
    - Over 65 Years Old: 11.52%
    - Limited Income (Under 100% of the poverty level): 19%

For more information refer to Appendix A: Social Vulnerability Analysis

Assumptions

The following assumptions reflect the approach with which the counties will fulfill the role of accommodating and assisting vulnerable populations during emergency operations.

- Resources will be limited and the County may not be able to meet the needs of special needs populations at all times.
- Local public health departments may be able to facilitate access to resources and case management services. However, they will not be able to provide onsite medical supervision and 24-hour nursing and environmental coverage.
- Many residents, especially those with special medical needs, may assume there will be local resources available to rescue them (e.g., first responders) and/or that the County will be able to provide specialized assistance to them in an emergency (e.g., pharmaceuticals, durable medical equipment, and special transport).
- Some populations with special needs may be less likely to have disaster plans and supplies due to limited cognitive, physical, and/or financial resources.
- Transportation will be an issue for some residents and visitors with special needs.
- Medically-fragile clients may not have access to regular services (e.g., dialysis, chemotherapy).
- Staffing levels at skilled nursing facilities, assisted living facilities, and outpatient clinics will be affected in an incident that impacts the general population.

- Many county departments and local non-profit organizations provide a critical link to and have the expertise to serve their clients with special needs.
- All partnering agencies are responsible for the development of agency-specific standard operating procedures (SOPs) that uphold their roles and responsibilities in supporting a public health response to an emergency.
- Public health nurses and clinicians might not be trained, nor should be expected or assigned, to care for individuals with special medical needs.
- Some home healthcare providers may not be able to serve their clients during an emergency/disaster.
- Patients who normally receive home healthcare services may need to be accompanied by a caregiver to a shelter. In such cases, the caregiver should be transferred with the evacuee and permitted to remain with that person as the caregiver is able.
- Those individuals who normally receive home healthcare services and who are unaccompanied during transfer and sheltering may require special attention.
- Patients evacuated from licensed nursing home or assisted living facilities to a shelter are the responsibility of the employees and management of that facility.
- Some individuals with functional needs will self-identify the need for assistance during emergency situations; others will not.
- Local planners have access to their jurisdictions' demographic profiles.
- Major needs of vulnerable populations may include assistance with the following activities associated with emergency or disaster response and recovery, including but not limited to:
    - Preparation, receiving notification, evacuation, and transportation
    - Sheltering
    - First aid and medical services
    - Temporary lodging and housing
    - Transition back to the community
    - Clean-up
    - Other emergency- and disaster-related programs, services, and activities
- Service animals may be utilized by some people, and accommodations for these animals should be considered when developing evacuation and sheltering plans. NOTE: Service animals are not considered pets since they perform functions to assist their owner in activities of daily living. In order to be permitted into a shelter with their owner, the service animal cannot pose a direct threat to other animals or individuals residing in the shelter and must have had prior training to remain calm in public situations.

Partnering Agencies

Federal

- Federal Emergency Management Agency (FEMA)
- Department of Health and Human Services (HHS)
- Centers for Disease Control and Prevention (CDC)
- National Organization on Disability (NOD)
- National Commission on Children and Disasters (NCCD)

State.

- Oregon Emergency Management (OEM)
- Oregon Health Authority
- Oregon Vulnerable Populations Coalition
- Info 211

Regional

- Linn-Benton Vulnerable Populations Committee
- Hospital Preparedness Program Region 2
- Oregon Cascades West Council of Governments
- Community Services Consortium
- American Red Cross Pacific Chapter
- Linn-Benton Senior Resource Network

Local

- Linn County Emergency Management
- Linn County Public Health
    - Linn County Mental Health
    - Linn County Developmental Disabilities
    - Linn County Child Welfare
    - Linn County Public Health Medical Reserve Corp.
- Benton County Emergency Management
- Benton County Public Health
    - Benton County Mental Health
    - Benton County Developmental Disabilities
- Albany Emergency Management
- Albany Police Department
- Albany Fire Department
- Albany Public Works

- City of Corvallis
- Mennonite Home
- Adventist Disaster Response
- Disability Service Advisory Council
- Samaritan Lebanon Community Hospital
- Samaritan Albany General Hospital
- Samaritan Corvallis Hospital

Legal Authorities

Law / Regulation	Citation	Purpose
FEDERAL		
Robert T. Stafford Disaster Relief and Emergency Assistance Act	P.L. 93-288, as amended, 1988	Integrates special needs issues into all phases of emergency management
HHS, Pandemic and All-Hazards Preparedness Act	P.L. 109-417, 2006	Addresses special needs or "at risk populations" including children, pregnant women, senior citizens, and other individuals who have "special needs"
Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users, 2005 (SAFETEA-LU)	P.L. 109-59	Requires state and local agencies to address special needs populations in their long-range transportation plans and improvement programs
Individuals with Disabilities in Emergency Preparedness (2004)	Executive Order 13347	Strengthens emergency preparedness with respect to individuals with disabilities
Americans with Disabilities Act (ADA) of 1990	P.L. 101-336	Mandates that all public and private sector facilities come into and remain in compliance, provide reasonable accommodations, and be accessible both physically and programmatically
Older Americans Act of 1965 (OAA)	P.L. 89-73	Used to authorize funds to assist older Americans in the recovery process
Individuals with Disabilities	H.R. 5441 (PL 109-295), Section 689	Used to develop disability-related guidelines for use by those who serve individuals with disabilities in emergency preparedness and

Law / Regulation	Citation	Purpose
		disaster relief
Rehabilitation Act of 1973	34 C.F.R. § 104; 29 U.S.C. § 794; Section 504	Holds local governments responsible for oversight of equal access by everyone to any program, service, or activity that receives federal funding; protects qualified individuals from discrimination based on their disability
Equal Opportunity for Individuals with Disabilities	42 U.S.C. §12132; 42 U.S.C. §12102(2)(B) & (C)	No qualified individual with a disability shall be excluded because of a disability from any programs, services, or activities provided by state and local governments
Nondiscrimination on the Basis of Disability in State and Local Government Services	28 C.F.R. § 35.104	Defines disabilities and states that individuals with disabilities may not be excluded from public accommodations by commercial facilities
Requirements For States and Long Term Care Facilities	42 CFR Part 483	Requires that institutions have their own plans and provide them to their respective regulatory agencies
STATE		
Department of Human Services Developmental Disabilities Oregon Administrative Rules	OAR 411-360-0130(8) OAR 411-325-0230	Requirement that adult foster homes and 24 hour care facilities must have an established emergency plan
Oregon State Fire Marshal	ORS 443.465(1)(b)	Requires that treatment homes and care facilities have an emergency preparedness plan

Command and Control

General

Linn and Benton Counties have each established a system for emergency management under the direction and control of their respective County Emergency Program Manager. Each county has their own Emergency Operations Plan which describes their emergency management system. It describes how the county's emergency decision-makers and management personnel coordinated to carry out emergency functions in any incident that requires ECC/EOC activation.

Direction and Control

All emergencies and disasters begin locally and initial response is by local jurisdictions working with county emergency management agencies. It is only after local emergency response resources are exhausted or local resources do not exist to address a given emergency or disaster that state emergency response resources and assistance may be requested by local authorities through their county emergency management organization.

Municipalities

The Chief Executives of the incorporated cities within the County are responsible for the direction and control of their local resources during emergencies, including requesting additional resources not covered under mutual aid for emergency operations. Such requests will be directed to County Emergency Management. Should the County be unable to support the request, the county will forward the request to Oregon Emergency Management, as outlined under the provisions of ORS 401.305.

Each city may establish an emergency management agency and appoint an emergency program manager. Cities that do so shall notify the county of the individual responsible for emergency management activities in their respective jurisdictions. Any city not choosing to establish an emergency management agency may develop a cooperative intergovernmental agreement with the county, specifying the emergency management activities to be accomplished at each level. If a city takes no action to increase its emergency management capability, such area will be considered in county planning and county resources will be deployed under the direction of the County to respond should emergency conditions arise that threaten residents of that city.

If a city adopts its own plan, that city will also:

- Adopt the National Incident Management System as the foundation for incident response within its jurisdiction;
- Acknowledge that the city government is charged with the responsibility of ensuring that city disaster plans are kept current;
- Ensure that those persons within city and county government who are charged with managing emergencies are made aware of their respective roles; and
- Ensure that the city plan is coordinated with this and their respective county plans.

Private/ Nonprofit Sector

Disaster response by local government agencies may be augmented by business, industry, and volunteer organizations. The Emergency Management Organization will coordinate response efforts with businesses and organizations, to include providing assistance as appropriate in action taken by industry to meet State emergency preparedness regulations governing businesses such as utility companies that provide essential services. Schools, hospitals, nursing/care homes and other institutional facilities are required by Federal, State or local regulations to have disaster plans. The County Emergency Program Manager will also work with voluntary organizations in the provision of certain services in emergency situations, typically through previously established agreements. In the preparedness context, essential training programs will be coordinated by the sponsoring agencies of such organizations as American Red Cross, Salvation Army, faith-based groups, amateur radio groups, and Community Emergency Response Teams. The Emergency Management Organizations may also provide the public with educational/instructional materials and presentations on whole community preparedness for the days immediately following a disaster.

Concept of Operations

General

The basic concept of emergency operations focuses on managing and using available resources for effectively and efficiently responding to all types of emergencies. For the purpose of Vulnerable Populations individuals, licensed facilities and non-profit organizations all play a role to assist emergency management organizations within the county to provide preparedness information and emergency planning training to minimize the need for emergency responders. This section of the plan outlines expectations and guides on what needs to be done to provide smooth response during an emergency.

Situational Assessment

Upon recognition of an emergency, Linn and Benton Emergency Management will perform an initial assessment of the situation. The purpose of the assessment is to collect information needed to conduct an appropriate and timely response and to make decisions about actions and resources.

Linn and Benton Emergency Management will use the assessment tools they would use in any natural or manmade event in order to develop an early assessment of an incident. The assessment tool might include the following major areas:

- Date and time the report was received
- Reporting person and contact information
- Summary of the nature of the event (e.g., type, size, who, when, where, how)
- Current partners involved
- Type and number of injuries (if any)
- Status of decontamination if the event warrants

- If relevant, determination of whether there is a list of persons who have been exposed to the environmental hazard
- Special needs populations requirements, if any
- Environmental health implications, if any
- Actions being taken and those already complete (e.g., treatment or environmental samples)
- Actions planned or recommended
- Notifications made
- Immediate resource needs for activation
- Expected support or resources from government and non-profit organizations

Organizational Structure

Each county has an organizational structure that is outlined in their individuals Emergency Operations Plan. These structures will be used any time their EOC/ECC is activated for an emergency or disaster. Each county will train with partners to this Vulnerable Population Annex to assure the partners understand the county organizational structure and where they fit. Training will provide partners with an expectation of they need to do to assist in making response to an emergency more effective.

Partners to this plan are also expected to develop, implement and train their staff on their individual organizational structure, to share this structure with the county emergency management organizations and with the other partners they will work with as a part of this vulnerable population plan

Counties/Cities

Each county has an Emergency Operations Center or Emergency Coordination Center that will be activated during an emergency. The location of each center and its activation procedures are outlined in the Counties Basic Plan. The county EOC/ECC will be the coordinating organization during an emergency that affects the majority of the county. For those situations where only a city is affected by an emergency, the city will stand up their EOC/ECC to coordinate their response efforts and contact county emergency management to advice them of their situation.

Licensing/Certifying authorities

Within both Linn and Benton Counties any public organization, such as public health or nonprofit organization, will have an emergency structure in place to provide emergency support to their clients prior to and immediately after emergency. This structure will follow the four phases of emergency management to assure that the clients are provided information on preparedness, the development of an emergency plan, training and exercising and how to conduct an after action evaluation to improve their emergency plan. County or city Emergency management organizations will provide resources to assist licensing or certifying authorities within their jurisdiction.

During an emergency it is expected by the county or city emergency management that any request for assistance from a licensed facility will come through the licensing or certifying authority or designee to the county or city EOC/ECC rather than from individual facilities.

Licensed Facility

As required under the authority of each licensing agency and associated administrative rules or statutes, all licensed facilities will have an emergency plan addressing emergencies most likely to affect their facility and clients. This information may be obtained from either the county or city hazard analysis found in their local area. Licensed facility plans should be regularly reviewed for revision, and should require ongoing training and exercises to take place on a regular basis with staff. Each plan will be reviewed and approved by the licensing or certifying authority or designee who will review the plans as required for licensing or certification renewal. The licensing or certifying authority of designee may request technical assistance by contacting their county or city emergency manager.

Emergency plans for all licensed or certified facilities should demonstrate consideration for initial and potentially extended periods in which emergency responders are not available.

Non-Profit Organizations

Non-profit organizations who are a part of this plan will work within the organizational structure as outlined in the individual county emergency operations plan. In addition they will develop their own organization structural plans that will be shared with their employee's, volunteers and county and city emergency management organizations. They will be expected to train and exercise these plans on a regular basis.

Immediate Actions

As an immediate action to a recognized incident that involves the local vulnerable population, coordination between City and/or County emergency management and leadership responsible for Vulnerable Population should be convened to discuss roles and responsibilities. This might include, but is not limited to, the following agencies:

- County Public Health
- County Emergency Management
- City Emergency Management
- Fire & EMS
- Police Agency
- American Red Cross
- Oregon Health Authority
- Council of Government
- Community Services Consortium

Dependent on the scope of the event, the following actions should be considered:

- Activate the County EOC/ECC and determine the ICS structure appropriate for the event
- Notify the state ECC regarding activation
- Decide on the extent of public health activation and notification to relevant staff, including, but not limited to, activation of a field team
- Prepare and submit a Situation Report (SitRep) to the and State ECC Office
- Review relevant Standard Operating Procedures
- Ensure that appropriate personal protective equipment (PPE) specific to the event is available to responders
- Initiate surveillance for injuries, infectious disease, and potential health concerns as a consequence of exposure to a hazardous material
- Consider messaging needs for the community

Activation of the County EOC/ECC

Activation of the County EOC/ECC will be based on the initial situational assessment. If the County EOC/ECC is activated the procedures outlined in the counties basic plan will be followed.

Response Actions

In this plan response actions are divided by evacuation or shelter-in-place events. Furthermore, each respective section is organized by the functional areas identified in the "special needs" definition: transportation, communication, medical care, supervision, and maintaining independence.

Particular events, such as a wind events or chemical releases, may require an evacuation. Others incidents, like chemical releases or winter storms, may require sheltering at a home, school, or place of work. Depending on the event, the area and duration of an evacuation or shelter-in-place order will vary. Many incidents will require a combination of evacuation and sheltering-in-place during the course of the event.

This section describes specific response activities to a range of potential hazards for which the County agencies will be responsible in the event of a public health-related incident involving special needs or vulnerable population individuals or facilities. Response actions will focus on the public health consequences of an incident, and associated recovery activities, as they pertain to vulnerable populations.

Evacuation

The Federal Emergency Management Agency (FEMA) defines evacuation as, *"the organized, phased, and supervised withdrawal, dispersal, or removal of civilians from dangerous or potentially dangerous areas, and their reception and care in safe areas."* The amount of time a community has to evacuate will depend on the hazard. In the event of a weather condition that can be monitored, such as a hurricane, a community might have several days to prepare. However, in many disasters people may not have the time to gather even the most basic necessities. This makes it essential to plan ahead for potential

hazards that may lead to evacuations. Planning and response actions must also consider the vulnerable populations within a community and address the various needs that may arise during an evacuation.

Each county will utilize their existing plans or procedures to implement evacuation procedures once the decision has been made that an evacuation needs to occur. Nothing in this document is meant to supersede existing policy. Under normal conditions determination that an evacuation will need to occur will be the responsibility of the Incident Commander or Unified Command. In some cases, where an emergency is affecting the entire community the EOC/ECC Director and their staff may be the group that determines when and where an evacuation may need to occur.

Counties will also use their current plans to coordinate Emergency Evacuation Sites that will be established after it is determined that an evacuation will occur.

Transportation

Evacuations depend on mobility, and people with certain disabilities may not be mobile enough to evacuate on their own or without assistance. In evacuation plans, planners must consider the transportation needs of the community. People with disabilities that decrease mobility may need additional help evacuating. People with the following types of disabilities may be mobile but functionally difficult to move during evacuations:

- Physical
- Sensory
- Chronic
- Behavioral
- Cognitive

Responsibilities:
Facilities

Each facility will develop and have in place an emergency plan which outlines their transportation needs and who they will receive their transportation from. It is expected that MOUs between the facilities and transportation providers will be in place to assure the appropriate level of staffing during an emergency. During an emergency each facility will:

- Will be responsible for coordinating transportation services for their clients
- Identify in their plan a primary and secondary location where their clients will be transported to if evacuation from the facility is necessary.
- Document where clients are transported to
- Communicate with clients relatives or care takes about the new location of the client
- Communicate with the licensing/certifying authorities on the action they are taking

County Emergency Management

Will provide assistance to facilities and individuals requiring transportation from an identified evacuation area during a disaster or emergency and will be responsible for the following actions:

- Will implement their County ESF 1 procedures as outlined in their Emergency Operations Plan
- Will provide support to those facilities that are unable to carry out their transportation needs as identified in their emergency plan
- Coordinate evacuation transportation as directed by the Incident Commander
- Facilitate movement of the public in coordination with other transportation agencies
- Provide transportation services for residents including those with special needs

Fire and EMS

Responsible for the following actions:

- Coordinate the provision of emergency medical services, as needed
- Ensure that triage, treatment, and transport of disaster victims is carried out in accordance with established protocols
- Coordinate transportation of the sick and injured with area hospitals or receiving facilities and other EMS agencies
- Provide personnel and resources to the incident as needed and as available
- Obtain additional or specialized support if required, from neighboring counties and state and federal agencies, through the County Emergency Communications Center or the EOC if it is operational
- Obtain assistance through mutual aid for the evacuation of patients from affected hospitals, nursing homes, or other special needs facilities

County Sheriff's and local Police Department

Responsible for the following based on situational assessments and available resources:

- Provide security, transportation, and escort for medical supplies, equipment, and personnel
- Assist with evacuations and coordination of needed equipment as appropriate

Public Health

Actions required of Public Health may include, but are not limited to, the following:

- Coordinate public messaging with ESF 15 and consider the communication needs of the community

Communication

Delivering information to vulnerable populations within the community may create additional challenges. Community members may not be able to hear verbal messages, see directional signs, or,

due to language barriers, understand communications. In addition, they may not understand how to seek help. Planners must communicate with all residents and/or visitors in ways that are easy to access and understand. Planners must also use communication methods that reach everyone in the community. Community members may have the following disabilities or limitations related to communication:

- Hearing
- Vision
- Speech
- Cognitive or intellectual limitation
- Limited proficiency in English

Responsibilities:

County Emergency Management

Lead agency for communication. Responsibilities may include, but are not limited to, the following:

- Implementation of the Communications portion of their Emergency Operations Plan
- Manage information during a disaster/emergency so that the most up-to-date and correct information is used to inform the public
- Coordinate with all agencies involved with the incident so that one message is used for public information to avoid any conflicts of released information
- Access all available media outlets to ensure that message is disseminated

Public Health

Actions requested of state or local Public Health may include, but are not limited to, the following:

- Coordinate public messaging with County Emergency Management and consider the health and medical communication needs of the community when providing evacuation information
- Make available and suggest the usage of partners, when required, to provide communication services for the deaf, hard of hearing, DeafBlind, or speech disabled
- Make available and suggest to partners the usage of the Language Line (phone # deleted) or other interpreter service vendors, when required, to provide interpreter services, allowing providers to communicate more effectively with their clients in a multicultural community
- Provide to partners and the community written materials that have been translated into multiple languages, and make these materials available on the County website when possible
- Provide communications that are available in a variety of formats and media so that they are accessible to all residents, particularly those with special needs
- Maintain an up-to-date list of contacts including all health and medical care agencies and service providers (e.g., nursing home facilities, home healthcare agencies, etc.)

Medical Care

Individuals with special medical needs often require help managing their illness, syndrome, or disorder. Caregivers may provide assistance; however, during an evacuation, people with chronic conditions can

lose equipment, medicine, or the care support they need and may not know how to obtain assistance. Planners should consider the medical needs of the community when creating disaster plans. Assistance may include, but is not limited to, the following:

- Managing unstable, terminal, or contagious conditions that require observation and ongoing treatment
- Managing IV therapy, tube feeding, and vital signs
- Providing dialysis, oxygen, and suction administration
- Managing wounds
- Operating power-dependent equipment to sustain life

Maintaining the provision of medical care to care facility residents during a disaster or emergency that requires evacuation presents unique challenges because of the age and infirmity of residents. Administrators and staff of these facilities should anticipate potential difficulties when emergencies or disasters occur and should be prepared to respond immediately.

During incidents that result in a call for evacuation, the needs of special medical needs populations might not be met in shelters established for the general population; the level of services will not equal what the client receives in his or her home or place of care. Shelters are considered an option of last resort for these clients; however, healthcare providers should ensure continued services during emergencies, including evacuation to local shelters, if appropriate.

Responsibilities:

See section 6 above for regulations, but according to the Oregon Health Regulations licensed facilities are required to:

- Develop a written plan for the protection and possible evacuation of residents
- Develop mutual assistance partnerships with other facilities to provide the support necessary when an incident occurs, whether or not evacuation results
- Prepare for the continuation of services during emergencies or disasters by developing a plan that addresses the provision of services to clients who will need assistance, including those clients residing in facilities
- Work collaboratively with their local health departments and their locality's emergency planning office in developing appropriate sheltering capability for special needs persons in their community
- Develop mutual support agreements with other agencies designed to ensure continuing care of both client populations in case of emergency-related needs

Fire and EMS

Responsible for the following:

- Coordinate the provision of emergency medical services, as needed
- Ensure that triage, treatment, and transport of disaster victims is carried out in accordance with established protocols

- Coordinate the transportation of the sick and injured with area hospitals or receiving facilities and other EMS agencies
- Provide personnel and resources to the incident as needed and as available
- Obtain additional or specialized support, if required, from neighboring counties and state and federal agencies, through mutual aid or county EOC/ECC
- Obtain mutual aid assistance for the evacuation of patients from affected hospitals, nursing homes, or other special needs facilities

Supervision

Supervision

Many people need help with activities of daily living and receive this support from family members or paid caregivers. In an emergency or disaster that requires evacuation, these individuals may lose the support of their caregiver. Planners should include caregivers at all stages of planning so that a proper response to people needing supervision help is more likely. Certain individuals, that may have particular conditions, will require supervision to make decisions affecting their welfare. These individuals include, but are not limited to, the following:

- Those with dementia
- Those with Alzheimer's disease
- Those with psychiatric conditions (e.g., schizophrenia or depression)
- Those with other mental disabilities
- Unaccompanied children
- The elderly

The evacuation of licensed facilities will be completed in accordance with their facility plan. Supervision of their clients will remain the facilities responsibility whether they are transported to the alternate care facility defined in their emergency plan, a shelter established by the American Red Cross, a shelter established by a non-profit organization or a shelter established by a governmental organization.

For those individuals who had no care giver prior to the emergency or whose care giver is off-site and cannot fulfill their responsibilities due to the emergency the shelter operators will be response to get medical supervision for those individuals coming into established shelters.

The evacuation of schools should be thoroughly planned prior to an emergency. Each school, public or private, within the Counties is responsible for developing a school emergency management plan that is based on the unique architectural, geographical, and student population characteristics of the school. Most school districts have district-wide emergency management plans that are developed in collaboration with community partners (e.g., fire, police, and EMS). An evacuation is "a critical incident response that involves the controlled movement of students from the campus to a pre-specified safe location, either to a remote area on-campus or to an off-campus location." Evacuation is to be used for situations in which locations outside the school are safer than inside the school, such a bomb threat.

Responsibilities:
For non-emergencies, the Linn and Benton Public Health, ESF 6 (Mass Care, Housing and Human Services), would be responsible for the following:

- Refer special needs adults, or children in need of supervision, to Adult Protective Services (APS) or Child Protective Services (CPS) respectively
- Provide advance notice, when possible (e.g., imminent hurricane), to Adult Protective Services and Child Protective Services so that they will be better prepared to assist individuals that require supervision during an incident that involves evacuation

Linn and Benton Public and Private Schools
Responsible for following the procedures and processes outlined in their Emergency Management Plans in the event of an evacuation, lockdown, or shelter-in-place. In incidents resulting in school evacuations, Linn and Benton Schools are responsible for the following actions:

- Develop evacuation procedures for ensuring the full participation of students and staff
- Ensure that there is more than one evacuation route that does not interfere with public safety vehicles and/or fire hydrants
- Ensure that the PHD clinic staff/nurses have emergency medical information, supplies, forms (e.g. *Authorization for Medication* forms), medications, and a medication log
- Maintain a list of children who are identified with the following:
- A disability under section 504 of the Rehabilitation Act of 1973
- An individual education plan (IEP) under the special education services
- A special medical need and/or family or social needs
- Determine how students will be accounted for
- Coordinate with safety and health officials to ensure that the needs of students are met
- Take direction from first responders once onsite

Licensed Care Facility
Required to:

- Develop a written plan for the protection and possible evacuation of residents
- Develop mutual assistance partnerships with other facilities to provide the support necessary when an incident occurs, whether or not evacuation results

All hospice and home healthcare providers are responsible for the following actions:

- Prepare for the continuation of services during emergencies or disasters by developing a plan that addresses the provision of services to clients who will need assistance, including those clients residing in facilities
- Work collaboratively with their local health departments and their locality's emergency planning office in developing appropriate sheltering capability for special needs persons in their community;
- Develop mutual support agreements with other agencies designed to ensure continuing care of both client populations in case of emergency-related needs

Public Health Department
Actions required of the public health department may include, but are not limited to, the following:

- Facilitate continuance of medical care services and the availability of medical supplies
- Provide guidance to health and medical care partners in the community to better prepare them to provide continuity of medical services to their clients; this can include providing referrals to other agencies or caregivers who are able to offer continued care during emergencies/disasters
- Partner with home healthcare agencies to make sure that caregivers are prepared to make arrangements for clients that may be transported to shelters (e.g., supply medications, accompany patients), if necessary
- Consider the implications that may cause individuals to experience stress and confusion (e.g., patients with dementia) due to a change of location
- Maintain an up-to-date list of contacts including all health and medical care agencies and service providers (e.g., nursing home facilities, home healthcare agencies, etc.)
- Serve as a liaison to ESF 4 (EMS) to ensure that individuals with special needs receive emergency medical services, as requested
- Partner with Public Schools to ensure that school evacuation plans include staff and children with disabilities (e.g., visual, hearing, mobility, cognitive, attention, and emotions) and special medical needs
- Consult with and provide guidance to schools on public health and medical-related issues for all incidents (e.g., pandemic influenza, toxic exposure, etc.)
- Work with Arlington Public Schools to ensure that the PHD clinic staff/nurses have emergency medical information, supplies, forms (e.g. *Authorization for Medication* forms), medications, and a medication log
- Partner with ESF 6 to help facilitate the case management of individuals with special medical needs that may enter shelters, and ensure that ESF 8 staff logs and maintains patient tracking documentation that details the status and transportation or movement of these individuals
- Collaborate with ESF 6, as requested, to help facilitate family reunification (e.g., use of the American Red Cross Safe and Well website or FEMA's National Emergency Family Registry and Locator System, which is activated to support Presidentially-declared disasters and mass evacuations)
- Assess behavioral health needs following disasters and coordinate to provide interventions to minimize harmful stress levels for both the general public and responder communities

Maintaining Independence

Many individuals with special needs are not self-sufficient with the loss of adequate support from caregivers. They may require regular care from a medical professional or need assistance to carry out daily activities, such as getting dressed, eating, and bathing. Individuals may also use a variety of support equipment, such as wheelchairs and walkers, to assist with their daily activities. In an emergency, these people may lose the aid they need to function independently. Without support, their conditions may worsen. Emergency plans should include ways to support these individuals. By receiving

needed support/devices, these individuals will be able to better maintain their independence. Such support resources that may be required include, but are not limited to, the following:

- Consumable medical supplies (diapers, formula, bandages, ostomy supplies, etc.)
- Durable medical equipment (wheelchairs, walkers, canes, scooters, etc.)
- Service animals
- Attendants or caregivers
- Pharmacy support

Emergency plans should outline how to obtain such resources. Special needs advocates can work with emergency managers to secure these resources from the state or local government, non-governmental organizations (NGOs), and the private sector. Supplying support to special needs individuals will enable them to maintain their pre-disaster levels of independence.

Responsibilities:

Linn and Benton County Emergency Management

Responsible for the following actions:

- Provide for the identification and management of resources that may be utilized during emergency or disaster situations
- Maintain a list of public and private sector resources that could be utilized during response efforts
- Use their own resources and equipment during emergency/disaster situations
- Maintain control over the management of the resources as needed to respond to the situation

Public Health

Actions required of the public health may include, but are not limited to, the following:

- Facilitate continuance of medical care services and the availability of medical supplies
- Develop and maintain a list of medical supply resources needed (e.g., portable oxygen, walkers, etc.)
- Coordinate with Linn and Benton EOC/ECC's to request needed resources and maintain an ongoing assessment of needs
- Work with health and medical care partners, NGOs, and other partners to ensure that supplies and other resources that may be needed during an emergency or disaster are available
- Develop and/or sustain partnerships with relevant organizations to obtain needed resources for durable medical equipment
- Partner with home healthcare agencies to ensure that caregivers accompany their clients to shelters, if necessary, and are prepared to bring the essential resources required for the care of the patient (e.g., medical supplies, durable medical equipment, etc.)
- Coordinate public messaging with County or local lead PIO and consider the health and medical communication needs of the community when providing evacuation information
- Maintain an up-to-date list of contacts including all health and medical care agencies and service providers (e.g., nursing home facilities, home healthcare agencies, etc.)

Shelter-in-Place

The term shelter-in-place is defined as, "a means of sheltering in the location in which an individual is present by going indoors, closing up the building, and waiting for the danger to pass." An event such as a chemical spill or release may require sheltering at a home, school, or place of work. The area and duration of a shelter-in-place order will depend on the event. Many emergencies/disasters will require a combination of evacuation and sheltering-in-place during the course of the event.

Possible issues to consider when planning for a shelter-in-place event include, but are not limited to, the following:

- People may be sheltered in their home, office, or wherever they happen to be at the time of the event
- Individuals may need to move to another (i.e., safer) location if not already in a shelter-in-place setting
- Individuals may find it difficult to return home if sheltered-in-place away from home
- People will want to return to their normal activities after an emergency and may need to leave for medical appointments (e.g., to receive dialysis)

The decision to evacuate a congregate setting and individuals with special needs residing in private residences requires careful planning and assessment of the risk. Medical and nursing home facilities may choose to shelter-in-place after deciding that it is the safest and most comfortable option for residents. To make sheltering-in-place more feasible, many congregate settings have been hardening their facilities by installing approved shutters, generators, etc. Although the facilities are ultimately responsible for their residents, the jurisdiction's Emergency Operations Plan (EOP) should pre-identify these facility locations and have an estimate of the number of individuals residing in each. It is also recommended that emergency managers work with these facilities whenever possible to help ensure that their plans adequately and realistically address possible hazards and emergencies.

Transportation

In some emergencies, individuals may need to move to another location if not already in a safe or shelter-in-place setting. Transportation to a shelter-in-place location may be more difficult for those with disabilities. Those with mobility limitations may require help returning home if they have sheltered-in-place away from home. Nevertheless, people will want to return to their normal activities after an emergency and may need to go to medical appointments (e.g., to receive dialysis). Planners should think about transportation needs before, during, and after an event and ensure that transportation is available. Mobility disabilities include, but are not limited to, the following:

- Physical
- Sensory
- Chronic
- Behavioral
- Cognitive

Responsibilities:

Linn and Benton Emergency Management

Coordinate transportation assistance to individuals who live in the community and have no transportation alternatives, they will provide support to licensed facilities, up on request, to support their emergency plan. Emergency management is responsible for the following actions:

- Process all transportation requests through the County EOC/ECC
- Coordinate evacuation transportation as directed by the Incident Commander
- Facilitate movement of the public in coordination with other transportation agencies
- Provide transportation services for Linn and Benton residents with special needs such as pre-arranged, specialized curb-to-curb transportation service for individuals who cannot ride the bus due to physical or mental conditions
- Nursing homes and other such facilities are responsible for coordinating transportation services for their clients

Fire and EMS

Responsible for the following actions:

- Coordinate the provision of emergency medical services, as needed
- Ensure that triage, treatment, and transport of disaster victims is carried out in accordance with established protocols
- Coordinate transportation of sick and injured people with area hospitals or receiving facilities and other EMS agencies
- Provide personnel and resources to the incident, as needed and as resources are available
- Obtain additional or specialized support, if required, from neighboring counties and state and federal agencies, through the Linn or Benton Emergency Communications Center
- Obtain mutual aid assistance for the evacuation of patients from affected hospitals, nursing homes, or other special needs facilities

City and County Law Enforcement

Responsible for the following based on situational assessments and available resources:

- Provide security, transportation, and escort for medical supplies, equipment, and personnel
- Determine the most viable transportation networks to, from, and within the emergency/disaster area and regulate the use of these transportation networks
- Provide staff implementation of evacuations and with the coordination with fire and public works or road departments as necessary

Public Health

Actions required of the public health departments may include, but are not limited to, the following:

- Coordinate public messaging with lead PIO and consider the communication needs of the community

Communication

Some people have limitations that make it difficult for them to understand important information about sheltering-in-place. Such problems make it hard to process information in an emergency and it is important to make sure that people with special needs get the information they need to stay safe. Planners must communicate with all individuals in ways that are easy to access and understand and must use communication methods that reach everyone in the community. Limitations associated with communication vary and may include:

- Hearing impairment
- Vision impairment
- Speech impediment or impairment
- Cognitive or intellectual limitation
- Limited proficiency in English

Responsibilities:

County Emergency Management

Lead agency for communication. Responsibilities may include, but are not limited to, the following:

- Implement the Communications Sections of their individuals Emergency Operations Plan
- Manage information during a disaster/emergency so that the most up-to-date and correct information is used to inform the public
- Coordinate with all agencies involved with the incident so that one message is used for public information to avoid any conflicts of released information
- Access all available media outlets to ensure that the message is disseminated

Role of Public Health

Actions required of the Public Health may include, but are not limited to, the following actions:

- Coordinate public messaging with County Emergency Management and consider the health and medical communication needs of the community when providing shelter-in-place information
- Make available and suggest to partners the use of communication services for the deaf, hard of hearing, DeafBlind, or speech disabled
- Make available and suggest to partners the usage of the Language Line (phone # deleted) or other interpreter service vendors, when required, to provide interpreter services, allowing providers to communicate more effectively with their clients in a multicultural community
- Provide written materials to partners and to the community that have been translated into multiple languages, and make these materials available on the County website when possible
- Provide communications that are available in a variety of formats and media so that they are accessible to all residents, particularly those with special needs
- Maintain an up-to-date list of contacts including all health and medical care agencies and service providers (e.g., nursing home facilities, home healthcare agencies, etc.)

Medical Care

Emergencies that require individuals or communities to shelter-in-place can cause hardship for those with medical needs that require close management. To address these challenges, planners should work closely with health and medical agencies to ensure that the management of care has been arranged for individuals with special medical needs during an emergency. Assistance may include, but is not limited to, the following:

- Managing unstable, terminal, or contagious conditions that require observation and ongoing treatment
- Managing IV therapy, tube feeding, and vital signs
- Providing dialysis, oxygen, and suction administration
- Managing wounds
- Operating power-dependent equipment to sustain life

Responsibilities:
According to the Oregon Health Regulations for the Licensure of Nursing Facilities, each nursing home facility is required to:

- Develop a written plan for the protection and possible evacuation of residents
- Develop mutual assistance partnerships with other facilities to provide the support necessary when an incident occurs, whether or not evacuation occurs

Licensed Care Facilities
All hospice and home healthcare providers are responsible for the following actions:

- Prepare for the continuation of services during emergencies or disasters by developing a plan that addresses the provision of services to clients who will need assistance, including those clients residing in facilities
- Work collaboratively with their local health departments and their locality's emergency planning office in developing appropriate sheltering capability for special needs persons in their community
- Develop mutual support agreements with other agencies that are designed to ensure continuing care of both client populations in case of emergency-related needs

Fire and EMS Organizations within the counties
Responsible for the following actions:

- Coordinate the provision of emergency medical services, as needed
- Ensure that triage, treatment, and transport of disaster victims is carried out in accordance with established protocols
- Coordinate transportation of the sick and injured with area hospitals or receiving facilities and other EMS agencies
- Provide personnel and resources to the incident as needed and as resources are available

- Obtain additional or specialized support, if required, from neighboring counties and state and federal agencies, through the County Emergency Communications Center or the EOC/ECC if it is operational
- Obtain mutual aid assistance for the evacuation of patients from affected hospitals, nursing homes, or other special needs facilities

Public Health

Actions required of the Public Health may include, but are not limited to, the following:

- Facilitate continuance of medical care services and the availability of medical supplies
- Provide guidance to health and medical care partners in the community to better prepare them to provide continuity of medical services to their clients; this can include providing referrals to other agencies or caregivers who are able to offer continued care during emergencies/disasters
- Work with health and medical care partners in the community to ensure that individuals with medical needs are able get out of the shelter location as soon as the hazard(s) are no longer a threat
- Provide guidance to partners and ensure that health and medical agencies have a backup plan if the need to shelter-in-place lasts longer than 72 hours
- Help partners to prepare to move individuals that cannot shelter-in-place
- Partner with home healthcare agencies to ensure that caregivers are prepared to safeguard clients in residential or inpatient units and maintain care and services to those that may be sheltered-in-place
- Maintain an up-to-date list of contacts including all health and medical care agencies and service providers (e.g., nursing home facilities, home healthcare agencies, etc.)
- Serve as a liaison to ESF 4 (EMS) to ensure that individuals with special needs receive emergency medical services, as requested
- Partner with ESF 6 to help facilitate the case management of individuals with special medical needs who may enter shelters, and ensure that ESF 8 staff log and maintain patient tracking documentation that details the status and transportation or movement of these individuals
- Collaborate with ESF 6, as requested, to help facilitate family reunification (e.g., use of the American Red Cross Safe and Well website or FEMA's National Emergency Family Registry and Locator System, which is activated to support Presidentially-declared disasters and mass evacuations)
- Assess behavioral health resources following disasters and coordinate to provide interventions to minimize harmful stress levels for both the general public and responder communities

Supervision

Many people need help with the activities of daily living and receive this support from family members or paid caregivers. An event that requires sheltering-in-place may separate people from the care they need. Therefore, plans should outline ways to find emergency support well before an event occurs. Certain individuals, that may have particular conditions, will require supervision to make decisions affecting their welfare. These individuals include, but are not limited to, the following:

- Those with dementia
- Those with Alzheimer's disease
- Those with psychiatric conditions (e.g., schizophrenia or depression)
- Those with other mental disabilities
- Unaccompanied children
- The elderly

The requirements necessary for sheltering-in-place at schools should be thoroughly planned prior to an emergency. Each school within the Counties is responsible for developing a school emergency management plan that is based on the unique architectural, geographical, and student population characteristics of the school. Most school districts have district-wide emergency management plans that are developed in collaboration with community partners (e.g., fire, police, and EMS). According to Emergency Management Plans, a shelter-in-place order is used "when students and staff must remain indoors during a period of time for events such as chemical, biological, and serious weather-related incidents" and is a short-term measure (minutes or hours, not days).

Responsibilities:
For non-emergencies:

Responsible for the following actions:

- Refer special needs adults or children in need of supervision to the Adult Protective Services or Child Protective Services, respectively
- Provide advance notice, when possible (e.g., imminent hurricane), to Adult Protective Services and Child Protective Services so that they will be better prepared to assist individuals that require supervision during an incident that involves evacuation

Public Schools
Each individual school district in Linn and Benton Counties is responsible for following the procedures and processes outlined in their Emergency Management Plan in the event of an evacuation, lockdown, or shelter-in-place. For incidents in which shelter-in-place is imposed (e.g., chemical release), schools are responsible for the following actions:

- Develop shelter-in-place procedures for ensuring the full participation of students and staff
- Create a schedule for learning, recreational activities, eating, and sleeping
- Ensure that the necessary supplies are available for students and staff throughout the shelter-in-place period
- Ensure that the clinic staff/nurses have emergency medical information, supplies, forms (e.g. *Authorization for Medication* forms), medications, and a medication log
- Maintain a list of children who are identified with the following:
    - A disability under section 504 of the Rehabilitation Act of 1973
    - An individual education plan (IEP) under the special education services
    - A special medical need and/or family/social needs
    - Determine how students will be accounted for

- Coordinate with safety and health officials to ensure that the needs of students are met
- Take direction from first responders once they are onsite
- Conduct shelter-in-place drills regularly
- Train clinic staff to prepare medications and first aid supplies for such emergencies and set up a place for providing first aid or giving medication

Licensed Care Facilities:
According to the Oregon Regulations for the Licensure of Nursing Facilities, each nursing home facility is required to:

- Develop a written plan for the protection and possible evacuation of residents
- Develop mutual assistance partnerships with other facilities to provide the support necessary when an incident occurs, whether or not evacuation occurs

Public Health:
The Oregon requires that all hospice and home healthcare providers are responsible for the following actions:

- Prepare for the continuation of services during emergencies or disasters by developing a plan that addresses the provision of services to clients who will need assistance, including those clients residing in facilities
- Work collaboratively with their local health departments and their locality's emergency planning office in developing appropriate sheltering capability for special needs persons in their community
- Develop mutual support agreements with other agencies designed to ensure continuing care of both client populations in case of emergency-related needs

Maintaining Independence

Many individuals with special needs are not self-sufficient if they lose support from caregivers. They may require regular care from a medical professional or may need assistance to carry out daily activities, such as getting dressed, eating, and bathing. Individuals may also use a variety of support equipment, such as wheelchairs and walkers, to assist with their daily activities. In an emergency, these people may lose the aid they need to function independently. Without support, their conditions may worsen. Emergency plans should include ways to support these individuals. By receiving needed support/devices, these individuals will be able to better maintain their independence. Such support resources that may be required include, but are not limited to, the following:

- Consumable medical supplies (diapers, formula, bandages, ostomy supplies, etc.)
- Durable medical equipment (wheelchairs, walkers, scooters, etc.)
- Service animals
- Attendants or caregivers

Shelter plans should outline how to obtain such resources. Special needs advocates can work with emergency managers to secure these resources from the state or local government, NGOs, and the

private sector. Supplying support to these special needs individuals will enable them to maintain their pre-disaster level of independence.

Responsibilities:

The Arlington County Department of Management and Finance, ESF 7 (Resource Support)

Responsible for the following actions:

- Provide for the identification and management of resources that may be utilized during emergency or disaster situations
- Maintain a list of public and private sector resources that could be utilized during response efforts

Each Arlington County Department and Agency

Responsible for the following actions:

- Use their own resources and equipment during emergency/disaster situations
- Maintain control over the management of the resources as needed to respond to the situation

PHD/ESF 8

Actions required of the PHD/ESF 8 may include, but are not limited to, the following:

- Facilitate continuance of medical care services and the availability of medical supplies
- Develop and maintain a list of medical supply resources needed (e.g., portable oxygen, walkers, etc.)
- Coordinate with ESF 7 to request needed resources and maintain an ongoing assessment of needs
- Work with health and medical care partners, NGOs, and other partners to ensure that partners are prepared to provide supplies and other resources that may be needed during emergencies/disasters
- Develop and/or sustain partnerships with relevant organizations to obtain needed resources for durable medical equipment
- Partner with home healthcare agencies to ensure that caregivers accompany their clients to shelters, if necessary, and are prepared to bring the essential resources required for the care of the patient (e.g., medical supplies, durable medical equipment, etc.)
- Coordinate public messaging with ESF 15 and consider the health and medical communication needs of the community when providing shelter-in-place information
- Maintain an up-to-date list of contacts including all health and medical care agencies and service providers (e.g., nursing home facilities, home healthcare agencies, etc.)

Dispensing

The Strategic National Stockpile (SNS), managed by CDC's Division of Strategic National Stockpile, is a cache of large quantities of pharmaceuticals, vaccines, medical supplies, and other equipment that can be deployed to any state in the U.S. in the event of a public health emergency (e.g., terrorist attack, flu outbreak, etc.) that overwhelms local supplies. Once federal and local authorities agree that the SNS is

needed, medicines will be delivered within 12 hours. Through the CDC's SNS Cities Readiness Initiative (CRI), state and large metropolitan public health departments have developed plans to respond to a large-scale bioterrorist event by dispensing antibiotics to the entire population of an identified metropolitan statistical area (MSA) within 48 hours.

A Point of Dispensing (POD) site will be set up in response to a large biological event and is used to dispense preventative therapy (antibiotics or vaccines) to residents and visitors to the Arlington County community in a timely and appropriate manner. Vulnerable populations will require special consideration and each POD site has provision for the management of populations that require special assistance.

Vulnerable populations are identified in an initial screening process and will be directed to an area where special assistance services will be available. The Special Assistance Area will provide a "one-stop" approach, allowing residents to complete the process without having to re-enter the clinic flow and negotiate the process.

The Strategic National Stockpile Plan, Annex IV to the Arlington County Public Health Emergency Response Plan, provides specific guidance to support functions related to the request and deployment of the SNS to the community and the subsequent dispensing and treatment facility activities.

Responsibilities:

PHD/ESF 8

In the event that POD sites are established in Arlington County, the PHD responsibilities will include, but are not limited to, the following actions:

- Provide various services and resources to accommodate individuals with special needs
- Interpretation services for individuals with limited-to-no English proficiency (e.g., Language Line)
- Technical resources (e.g., Interpretive and pocket talkers) and services (e.g., Virginia Relay, sign language interpreters) to assist those with hearing impairments
- Resources to help individuals who are visually impaired (e.g., lighted magnifying glasses, large print documents, documents in Braille, etc.)
- Coordinate with the Department of Human Services Aging and Disabilities Service Division to provide prophylaxis to nursing homes, assisted living facilities, senior high rises, and other at-risk populations such as the homebound in Arlington County
- Encourage residents to pick up medication for neighbors and family members who are not able to pick up medication at a designated POD site
- Assist in the coordination of transportation resources (e.g., STAR, etc.) to vulnerable populations such as nursing homes, the homeless, and the homebound
- Be prepared to utilize all communication systems and media outlets to provide information to the general population and vulnerable populations about the event and the dispensing activities
- Coordinate with ESF 15 to disseminate information to vulnerable populations utilizing existing media relationships and partnerships with organizations that serve special needs groups

- Ensure that PHD and other POD staff are familiar with and follow VDH's policy regarding the ability to provide medication/vaccine to unaccompanied minors (i.e., an individual under the age of 18 years who reports to a POD to receive prophylactic medication or vaccination without a parent or guardian)

See other relevant materials:

Arlington County Public Health Emergency Response Plan Annex IV, Strategic National Stockpile Plan

Emergency Response

Response during an emergency will be coordinated at the county level through its EOC/ECC using the National Response Framework, National Incident Management System (NIMS) and the Incident Command System (ICS). City EOC/ECCs will coordinate their response with their counties to assure there is a clear understanding of response efforts, expectations and potential response requests. Individuals, licensed facilities, and licensure organizations have a role in being prepared for an emergency and those expectations are outlined below.

There are four phases of emergency management which when properly followed by emergency responders and those facilities or individuals who fall within this plan will assure a smooth and effective response.

Preparedness – Consists of measures taken to build, sustain and improve the capability to prevent, protect against, respond to and recovery from incidents. Preparedness is a continuous process that includes planning, training and exercises. Emergency plans should be developed to outline what action will be taken during an emergency and should include training with staff or care takers as well as annual exercises to assure the plans are workable. These efforts help to minimize the need for emergency responders by assuring individuals and facilities can take care of themselves.

Response – It is during this phase that the preparedness efforts, emergency planning and training will be put to the test. Individuals and facilities will activate their emergency plan at the level necessary. The expectations of local emergency management is that adequate efforts has gone into the preparedness phase that emergency responders will only be needed in the most severe situations and that the majority of individuals and facilities will be able to take care of themselves.

Recovery – Restoring individuals and facilities back to their normal operations in the shortest period of time is the objective of recovery. The foundation of a good preparedness effort coupled with response during an emergency will assure that recovery will take place quickly and effortlessly with little or no impact on individuals or clients.

Mitigation – This phase allows us to look back and see what worked and what can be improved. Individuals and facilities need to look at their response and determine if their emergency plans need to updated, coordination with other agencies or care takers need to be changed or if additional training would be helpful.

Appendix F List of Designated Focal Points

Services may be attained from SDS at any of the following locations:

Albany Senior and Disability Services

1400 Queen Avenue S.E., Suite 206

Albany, OR 97322

(541) 967-8630 Voice & ADRC

(800) 638-0510 Toll free

(541) 924-8402 TTY

(541) 812-2581 Fax

Corvallis Disability and Veterans Services

301 SW 4th Street

Corvallis, Oregon 97333

(541) 758-1595 Voice

(800) 508-1698 Toll free

(541) 758-3126 TTY

Toledo Senior and Disability Services

203 N. Main Street

Toledo, OR 97391

(541) 336-2289 Voice & ADRC

(800) 282-6194 Toll free

(541) 336-8103 TTY

(541) 336-1447 Fax

Senior Center Locations Include:

Linn County

Albany Senior Center
489 Water Avenue NW
Albany, OR 97321
541-917-7760

Lebanon Senior Center
80 Tangent Street
Lebanon, OR 97355
541-258-4919

Sweet Home Senior Center
880 18th Avenue
Sweet Home, OR 97386
541-367-4775

Benton County

Chintimini Senior Center
2601 Tyler Street NW
Corvallis, OR 97330
541-766-6959

Lincoln County

Confederated Tribes of Siletz
PO BOX 549 Government Hill
Siletz, OR 97380
541-444-9169

Lincoln City Community Center
2150 NE Oar Place
Lincoln City, OR 97367
541-994-2722

Newport Senior Center

20 SE 2nd Street

Newport, OR 97365

541-265-9617

Waldport Community Center

265 Hemlock Street

Waldport, OR 97394

541-563-8796

COPY

MEMORANDUM OF UNDERSTANDING (MOU)

Purpose: To address coordination of information services delivery between Oregon Cascades West Council of Governments Senior and Disability Services (SDS) Call Center and 211info, a 501(c) (3) organization located in Portland, OR.

The Parties:

a. SDS's mission is to assist older adults and persons with disabilities in Linn, Benton and Lincoln Counties to live as independently as possible with a range of accessible, quality services that meet their diverse needs and preferences.
b. 211info is a 501(c) (3) organization located in Portland, Oregon. It provides information and referral services to connect the people of Oregon and Southwest Washington with needed health and human services.

Operating Principles: It is the intention that both parties will work to create, deliver and maintain a high quality information and referral system for the region by adhering to Alliance of Information and Referral (AIRS) Standards and by cooperating with one another to ensure that accurate information is ultimately available to the user.

Organizational Needs: Each party to this MOU is a separate and independent organization. As such, each organization retains its own identity in providing service and each organization is responsible for establishing its own policies and financing its own activities.

Methods of Cooperation: It is agreed that both parties will arrive at a mutually acceptable process for sharing resources and tracking cross referrals. Both parties will attend regularly scheduled meetings to discuss areas of interest and coordination of training opportunities will be pursued.

To help ensure coordination between the two information and referral services and better serve residents of Linn, Benton and Lincoln Counties, Senior and Disability Services and 211info agree to the following:

If 211info staff receives a call about an aging/older adult or disability-related service, 211info staff will either refer or transfer the caller to the Senior and Disability Services Call Center. It is agreed that appropriate aging and disability-related questions include but are not limited to:

- Advocacy
- Adult Day Care
- Application for SNAP and/or Medicaid benefits
- Assessment for Services
- Caregiver Resources
- Financial Assistance
- Housing Resources
- In-home or community based assistance

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- Insurance Counseling
- Legal Assistance
- Respite
- Transportation
- Veterans Services & Benefits

Additionally, 211info will transfer directly to the Senior and Disability Services Call Center if the caller indicates a question related to the following areas:

- Abuse, Neglect, Exploitation – older adults or adults with disabilities 18+
- Emergency Food, Food Insecurity – older adults or adults with disabilities 18 +
- Emergency Housing, risk of failed housing placement – older adults or adults with disabilities 18 +

If the Senior and Disability Services Call Center receives a call for information on services other than aging and disability-related services during the regular business day the caller will be referred or transferred to 211info.

Period of Review: This MOU will be officially reviewed in two years. Amendments may be considered at any time and enacted based on the consensus of the parties.

Legal Effect: It is acknowledged by both parties that nothing stated in this MOU is legally binding.

Termination: Either party may terminate this agreement with 90 days written notice with or without cause.

Signatures:

Signed by

Cynthia Solie
Executive Director
OCWCOG
1400 Queen Ave SE
Albany, OR. 97322

Liesl Wendt
CEO
211info
621 SW Alder, Suite 810
Portland, OR 97205

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MEMORANDUM OF UNDERSTANDING (MOU)

The Memorandum of Understanding is made on November 1, 2011 by and between Oregon Cascades West Council of Governments Senior and Disability Services (SDS) and Samaritan Health Services, Senior Companion Program (SCP). It shall remain in effect until termination by either party and will be reviewed every two years by the parties.

The Parties:

a) SDS's mission is to assist older adults and persons with disabilities in Linn, Benton and Lincoln Counties to live as independently as possible with a range of accessible, quality services that meet their diverse needs and preferences.
b) The Senior Companion Program is a federally funded volunteer program for people 55 years and older, and is part of Senior Corps, which fosters civic engagement through service and volunteering. The program coordinates companion and transportation services for seniors in the Linn, Benton and Lincoln county-area so they can remain in their own homes and live as independently as possible

PURPOSE:

To address screening and coordination of consumers for any and all services they may need and be eligible to receive, and to assure delivery of the right services at the right time to the right consumer by the right organization.

Common Objectives:

Both parties will work together to insure that consumers who contact either organization will receive information, referrals, and assistance that addresses their needs, and further the mission of both parties to help seniors and persons with disabilities stay independent and in their own homes.

Referral Process:

Both parties agree to a process and cross referrals for consumers seeking assistance through SDS's staff and the Aging and Disability Resource Connection (ADRC) call center and the SCP staff. To help ensure coordination between the two, SDS and the SCP agree to the following:

SDS

When consumers contact the ADRC call center, staff will provide information about all potential programs that could meet the consumer's needs and preferences. If the call center and the consumer determine that they prefer and would qualify for the SCP services, the ADRC staff will refer them to the organization via email to SCP staff, ***or*** by giving them the direct phone number, telling them SCP's hours of operation. The ADRC staff will follow-up with the consumer in 10-14 days to ask if the referral met their needs.

Additionally, consumers who receive limited benefits from SDS may be referred to SCP by other SDS staff (ie. Family Caregiver Support Program, low-income medical benefits staff, etc.), and will follow the same referral process. All SDS staff will be trained on the services provided by SCP as needed.

SCP
When SCP is the first consumer contact, the SCP staff will screen and assess the callers' needs, and *if appropriate* refer to SDS for more information about *all* programs that could meet their needs and preferences.

Additionally, if during the course of providing volunteer services for a consumer, it becomes evident that they may need additional information and assistance about supplemental services or programs, SCP staff will give the consumer information (brochure, phone number, etc) about SDS, ADRC and recommend they call OR make the referral directly. If there are concerns about abuse or neglect, SCP staff will call the ADRC directly and discuss the concerns.

All SCP staff will be trained on services provided by SDS as needed.

Confidentiality:
Both parties will share the minimum amount of information necessary to make the referral and assist with service delivery as agreed upon by the consumer.

Period of Review: This MOU will be officially reviewed in two years by the ADRC Advisory Council and the Senior Companion Program governing body.

Legal Effect: It is acknowledged by both parties that nothing stated in this MOU is not legally binding, but set-forth in a spirit of cooperation to better serve consumers.

Signatures:

Cynthia Solie
Executive Director
OCWCOG
1400 Queen Avenue SE
Albany, OR 97322

Suzette Boydston

Letter of Agreement

MEALS REIMBURSEMENT AGREEMENT
BETWEEN
THE CONFEDERATED TRIBES OF SILETZ INDIANS OF OREGON
AND OREGON CASCADES WEST COUNCIL OF GOVERNMENTS
SENIOR MEALS/MEALS ON WHEELS

This Letter of Agreement is voluntarily entered into by the Confederated Tribes of Siletz Indians of Oregon (Siletz Tribe) and Oregon Cascades West Council of Governments Senior Meals/Meals on Wheels (Senior Meals).

Senior Meals will provide The Confederated Tribes of Siletz Indians a monthly list detailing the names and number of meals received by Siletz Elders. The Confederated Tribes of Siletz Indians will pay Oregon Cascades West Council of Governments Senior Meals Program $3.00 per meal provided. The Confederated Tribes of Siletz Indians will pay Oregon Cascades West Council of Governments monthly.

Either party may terminate this Letter of Agreement. The request to terminate the agreement, along with the effective date of termination, will be in writing.

Signatures:

Approved for the Confederated Tribes of Siletz Indians of Oregon:

Delores Pigsley — 2/20/04
Tribal Chairman — Date

Approved for OCWCOG Senior Meals/Meals on Wheels

William R Wagner, Executive Director — 3/18/04
Date

MEMORANDUM OF UNDERSTANDING (MOU)

The Memorandum of Understanding is made on July 1, 2011 by and between Oregon Cascades West Council of Governments Senior and Disability Services (SDS) and Volunteer Interfaith Caregivers (VIC). It shall remain in effect until termination by either party and will be reviewed every two years by the parties.

The Parties:

a) SDS's mission is to assist older adults and persons with disabilities in Linn, Benton and Lincoln Counties to live as independently as possible with a range of accessible, quality services that meet their diverse needs and preferences.
b) VIC is a 501 (c) 3 organization that coordinates volunteer services for seniors and persons with physical disabilities in the Philomath and Corvallis area so they can remain in their own homes and live as independently as possible

PURPOSE:

To address screening and coordination of Philomath and Corvallis consumers for any and all services they may need and be eligible to receive, and to assure delivery of the right services at the right time to the right consumer by the right organization.

Common Objectives:

Both parties will work together to insure that consumers who contact either organization will receive information, referrals, and assistance to meet their needs and further the mission of both parties to help seniors and persons with disabilities stay independent and in their own homes.

Referral Process:

Both parties agree to a process for referrals and cross referrals of consumers seeking assistance through SDS's staff AND Aging and Disability Resource Connection (ADRC) call center and VIC's volunteer office staff. To help ensure coordination between the two, SDS and VIC agree to the following:

SDS

When consumers contact the ADRC call center, staff will provide information about programs that could meet the consumer's needs and preferences. If the call center and the consumer determine that they prefer and would qualify for VIC's program services, the ADRC staff will refer them to the organization by giving them the direct phone number, telling them their hours of operation, and asking the caller to tell VIC that SDS. ADRC made the referral. The ADRC staff will follow-up with the consumer in 10-14 days to ask if the referral met their needs.

Additionally, consumers who receive limited benefits from SDS may be referred to VIC by an SDS benefit or service worker. All SDS staff will be trained on the services provided by VIC via communication with VIC and opportunities for staff presentations and follow the same referral process.

VIC

When a person calls VIC with a request for an **on-going** service, the VIC office volunteer will ask if they were referred by SDS or ADRC. If they were **not referred by** SDS/ADRC, another agency or a member church, the office volunteer will recommend that the person contact SDS/ADRC to receive information about **all** programs that could meet their need or preference. If the person **was referred by** SDS/ADRC, another agency or their church, VIC will begin the process to complete their request for service.

Additionally, if during the course of providing volunteer services for a consumer, it becomes evident that they may need additional information and assistance about additional services or programs, VIC staff will give the consumer information (brochure, phone number, etc) about SDS, ADRC and recommend they call. If there are concerns about abuse or neglect, VIC staff will call the ADRC directly and discuss the concerns.

Confidentiality:
Both parties will share the minimum amount of information necessary to make the referral and assist with service delivery as agreed upon by the consumer.

Period of Review: This MOU will be officially reviewed in two years by the ADRC Advisory Council and VIC Board of Directors.

Legal Effect: It is acknowledged by both parties that nothing stated in this MOU is legally binding, but set-forth in a spirit of cooperation to better serve consumers.

Signatures:

Cynthia Sobie
Executive Director
OCWCOG
1400 Queen Avenue SE
Albany, OR 97322

Sandra W. Potter
VIC Board President
501 NW 25th Street
Corvallis, OR 97330

Memorandum of Understanding

Medicaid-funded long term care (LTC) services are legislatively excluded from Coordinated Care Organization (CCO) budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to coordinate care and share accountability for individuals receiving Medicaid-funded long term care services.

This is a non-binding agreement between Intercommunity Health Network Coordinated Care Organization (IHN CCO) and Oregon Cascades West Council of Governments (OCWCOG). The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system.

Based on the good faith description of the roles and responsibilities of the entities participating in the proposed agreement to coordinate care and share accountability for Medicaid funded long term care, Intercommunity Health Network CCO and Oregon Cascades West Council of Governments agree to participate in the following activities (please note that this MOU does not include terms related to non emergency Medicaid transportation). The term of this agreement will start upon final approval of OHA and DHS and will end after 12 months.

1. Prioritization of high needs members in LTC

CCO Expectation	AAA Expectation	IHN CCO/OCWCOG agreements:

• CCO will define universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs members receiving Medicaid funded LTC services.
  ○ CCO will factor in relevant referral, risk assessment and screening information from local AAA offices and LTC providers.
  ○ CCO will define how it will communicate and coordinate with AAA when assessing members receiving Medicaid-funded LTC services.
	• AAA will provide CCO with access to information needed to identify members with high health care needs.
	• AAA will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid AAA offices into CCOs' individualized care plans for members with intensive care coordination needs.
		After IHN CCO contract implementation with OHA, IHN CCO and OCWCOG will move towards sharing information about potentially high risk members.
		
		IHN CCO and OCWCOG will determine key information generated by existing risk assessment information including those in SPL 1-3 to help determine high risk members.
		
		IHN CCO and OCWCOG staff will also determine information for members that are known to have complex medical conditions, high ER usage, or other complicating circumstances on an individual basis.
		
		IHN CCO staff will share information from existing systems and data systems under development that demonstrate patterns of high risk/utilization of medical services for shared clients.

1. Prioritization of high needs members in LTC		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG agreements:
• MOU will address how CCO and AAA will hold themselves mutually accountable to meeting these expectations.		IHN CCO staff will identify staff liaisons to work with OCWCOG in the identification of new clients or people who are transferring to the region needing assessment for Medicaid LTC services. Methods of information sharing: • Information will be shared monthly. • Information will be shared electronically if available. • As IHN CCO and DHS/OHA data systems are improved, new data sources will be incorporated into information sharing. Designated contact staff (if different than designated MOU contact) will be designated by each entity. IHN CCO and OCWCOG will hold each other accountable in the following ways: • Within the timeframe of this agreement. • Meet to review the processes that have been defined in this MOU to assess MOU agreements, identify strengths and challenges or barriers. The MOU may be modified at this time. • Meet to evaluate MOU and determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.

2. Development of individualized care plans

CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCOs individualized person-centered care plans will include information about the supportive and therapeutic needs of each member, including LTC services and supports needs. ○ Plans will reflect member or family/caregiver preferences and goals captured in AAA service plans as appropriate. ○ Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA and with LTC providers.	• AAA will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid AAA offices into CCOs individualized care plans for members with intensive care coordination needs.	Within the timeframe of this agreement, IHN CCO will share individual care plans for members with intensive care coordination needs also served by OCWCOG. The care plans will be shared as they are updated by the IHN CCO. IHN CCO will work to include OCWCOG contact information for each individual's care coordinator and/or primary care home for purposes of care coordination. Within the timeframe of this agreement, OCWCOG will share key client information with the IHN CCO for individuals with intensive care coordination needs that have an individual care plan with the IHN CCO. Information will include relevant items from the long term care client assessment and planning system (CAPS). OCWCOG will share this information with IHN CCO on a regular basis and when plans are updated. Key client information will include: • Clients choice of living situation and preferences. • OCWCOG liaison or case manager contact information. • LTC provider contact information. IHN CCO and OCWCOG will hold each other accountable in the following ways: • Meet to review the processes that have been defined in this MOU to assess MOU agreements, identify strengths and challenges or barriers. The MOU may be modified at this time. • Meet to evaluate MOU and determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.
• MOU will address how CCO and AAA will hold themselves mutually accountable to meeting these expectations.		

3. Transitional care practices		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCO will demonstrate how it will coordinate and communicate with AAA to incent and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650.	• AAA will demonstrate how it will coordinate and communicate with CCO to incent and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650.	Within the timeframe of this agreement, IHN CCO and OCWCOG will meet to determine the ways that each party will effectively and efficiently coordinate the care transitions of members receiving LTC services and supports. The details of the coordination discussions will include but is not limited to the following: • Team discharge planning. • Use of OCWCOG Hospital to Home Program as appropriate. • Fully engage member and family/natural supports. • Ability to coordinate funds for accommodations in the home. • Reporting systems that deliver data in real time. • Support member choice as primary consideration in planning. • Support least cost options for LTC expenditures. • Planning will include consideration of additional community supports to stabilize member health and well being. IHN CCO and OCWCOG will hold each other accountable in the following ways: • Meet to review the processes that have been defined in this MOU to assess MOU agreements, identify strengths and challenges or barriers. The MOU may be modified at this time. • Meet to evaluate MOU and determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.
• MOU will address how CCO and AAA will hold themselves mutually accountable to meeting these expectations.		

4. Member engagement and preferences		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCO will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with AAA where relevant to LTC service planning.	• AAA will actively engage individuals in the design, and where applicable, implementation of their LTC service plan, in coordination with CCO where relevant to health care treatment and care planning.	Within the timeframe of this agreement, the parties will meet to develop an understanding of the opportunities and process for member engagement in the care planning process. The agreement will address the following: • Outline of the current care planning process that OCWCOG staff engage in with LTC service clients. • Outline current treatment and care planning process used by IHN CCO for shared members. • Develop clear guidelines on the exchange of information related to treatment and care plans for LTC service clients. • Establish a review date for the evaluation of activities and modifications as needed.
• MOU will address how CCO and AAA will hold themselves mutually accountable to meeting these expectations.		

5. Establishing member care teams		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCO will support the flow of information to AAA. • The CCO appointed lead provider or care team will confer with all providers responsible for a member's care, including LTC providers and AAA. • To support care teams, CCO will o Work with AAA to ensure that it identifies members receiving LTC services. o Include LTC providers and	• AAA will define roles, responsibilities and process for assignment of and participation in the CCO care team, including coordination with CCO lead care coordinator, for members needing routine and intensive care coordination. • AAA will ensure that CCO providers/care teams are notified of which CCO members are receiving LTC, the relevant	The parties will work with each other as outlined in previous sections of this MOU to designate lead staff members for assisting in the determination of the appropriate members for care teams. The care team membership will vary according to the needs of the members and will focus on members needing the highest level of care coordination. The Medicaid LTC provider network (CBC) will participate in the discussions of what role and responsibilities they will play for care coordination to insure the best care plan for each member. The use of technology will be investigated to maximize that ability

5. Establishing member care teams		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
AAA case managers as part of the team based care approach. • Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services.	local AAA office contact, and contact for relevant LTC provider. • AAA will have knowledge of and actively participate in CCO team based care processes when appropriate. • DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.	to include relevant parties in the discussion including phone, video, and computer based interactions. Both parties will review by July 2013, this section of the agreement to evaluate progress and make adjustments in the development of care teams to support members in LTC services.
• MOU will address how CCO and AAA will hold themselves mutually accountable to meeting these expectations.		

6. Use of best practice		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCO will describe capacity and plans for ensuring that best practices are applied to individuals in LTC settings, including best practices related to care coordination and care transitions.	• AAA will support CCO efforts to implement best practices approaches, and will share promising and best practices including care coordination, care transitions and evidence based healthy aging programs related to serving individuals in LTC settings with CCOs.	Within the timeframe of this agreement, the parties will meet to discuss options for addressing this domain.

7. Use of health information		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• As part of the HIT improvement plan, CCO will identify a strategy to partner with the LTC system to improve upon any existing efforts to share information electronically.	• AAA will partner with CCO in developing electronic information sharing strategy. • DHS/APD will develop mechanisms to improve the sharing of relevant DHS information with CCOs.	Within the timeframes of this agreement, the parties will meet to evaluate the HIT options and systems from IHN CCO as well as DHS and determine if there are opportunities to improve communication with HIT not already in use. IHN CCO will work with OCWCOG to ensure integration into the CCO planning and collaborative processes around HIT.

8. Member Access and Provider Responsibilities		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCO describes: ○ How it will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services. ○ How it will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication. ○ How members will be informed about access to nontraditional providers, if	• AAA will provide education materials to Medicaid clients, contracted providers, family caregivers and client-employed providers on member access to services through the CCO.	Within the timeframe of this agreement, the parties will meet to review member education materials and discuss improvements to the materials as well as ongoing cross training of staff from each organization to ensure member access. IHN CCO will work with OCWCOG to ensure integration into the CCO planning and collaborative processes around member access and provider responsibilities.

available through the CCO, including personal health navigators, peer wellness specialists where appropriate, and community health workers. • Tools developed for members should be accessible to individuals receiving LTC services and supports and/or their family or representative.		

9. Outcome and quality measures		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCO will demonstrate an acceptable level of performance related to shared accountability for individuals receiving LTC services and supports.	• AAA will demonstrate an acceptable level of performance related to shared accountability for individuals served by the CCO and receiving LTC services and supports.	IHN CCO will work with OCWCOG to ensure integration into the CCO planning and collaboration processes around outcome and quality measures.

10. Governance Structure		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• How CCO governance structure will reflect the needs of members receiving LTC services and supports through representation on the governing board or community advisory council.	• AAA will participate at the community level in the board / Advisory panel for LTC perspective as needed. • AAA will articulate how the membership of the local	IHN CCO will support the recruitment of OCWCOG SSAC and DSAC members to participate in the CAC. IHN CCO will designate an appropriate staff member to participate on the OCWCOG SSAC/DSAC as a member and liaison for CCO services.

	governing boards, Advisory Councils, or governing structures will reflect the needs of clients served by the regional CCO(s). • DHS/APD will articulate how APD will include CCO participation in their policy development structures.	OCWCOG staff will participate in the Operations group to insure ongoing input to the development of the CCO and maximize the coordination between the parties.

11. Learning Collaborative		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• Each CCO participates in the learning collaborative described in ORS 442.210.	• AAA will participate in learning collaborative on relevant topics such as care coordination, LTC, best practices.	IHN CCO and OCWCOG will participate in learning collaborative as needed.

12. Role of person centered primary care home (PCPCH)		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCO will partner with the local AAA office to develop a method for coordinating services with PCPCH providers for members receiving LTC services.	• AAA will develop methods and protocols for supporting and coordinating with PCPCH providers. • AAA will support coordination between LTC providers and PCPCH providers.	Within the timeframe of this agreement, the parties will review the IHN CCO progress in developing PCPCH for members and discuss opportunities for support.

13. Safeguards for members		
CCO Expectation	AAA Expectation	IHN CCO/OCWCOG activities
• CCO will coordinate safeguards, including access to peer wellness specialists, personal health navigators, and community health workers where appropriate and develop processes ensuring these services are coordinated with LTC services to maximize efficiencies. • CCO will describe how planned or established mechanisms for managing member complaints and grievances will be linked to, coordinated with, and inform team-based care practices for members in LTC.	• AAA will ensure that choice counseling materials and processes reflect member rights, responsibilities, and understanding of benefits. • AAA will ensure that staff understand and communicate safeguards, including use of peer wellness specialists, personal health navigators, and community health workers and ensure that these services are coordinated with LTC services to maximize efficiencies. • AAA will coordinate with CCO to manage member complaints and grievances for CCO members.	Within the timeframe of this agreement, IHN CCO will work with OCWCOG to ensure integration into the CCO implementation planning and collaborative processes around safeguards for members.

14. Administrative Expectations

IHN CCO and OCWCOG will meet at least every other month. The parties will draft a report of progress based on the agreement to report to the IHN CCO Board, the OCWCOG Board and interested parties quarterly, beginning Quarter 1, 2013. The parties will also draft a report based on this agreement annually for the INH-CCO Board, the OCWCOG Board and interested parties.

Signatures and Contacts

For: Intercommunity Health Network CCO

The designated contact person is:

Kelley First name	Kaiser Last name
KelleyK@samhealth.org Email	541-768-5341 Phone
Kelley Kaiser Authorizing Signature	June 15, 2012 Date

For: Oregon Cascades West Council of Governments

The designated contact person is:

Cynthia First name	Solie Last name
CSolie@OCWCOG.ORG Email	541.924.8465 Phone
Cynthia Solie Authorizing Signature	6/15/12 Date

Appendix H Statement of Assurances and Verification of Intent

For the period of January 1, 2013 through December 31, 2016, Oregon Cascades West Council of Governments (OCWCOG) accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 106-510) and related State law and policy. Through the Area Plan, OCWCOG shall promote the development of a comprehensive and coordinated system of services to meet the needs of older individuals and individuals with disabilities and serve as the advocacy and focal point for these groups in the Planning and Service Area. OCWCOG assures that it will:

Comply with all applicable State and federal laws, regulations, policies and contract requirements relating to activities carried out under the Area Plan.

Conduct outreach, provide services in a comprehensive and coordinated system, and establish goal objectives with emphasis on: a) older individuals who have the greatest social and economic need, with particular attention to low income minority individuals and older individuals residing in rural areas; b) older individuals with significant disabilities; c) older Native Americans; and d) older individuals with limited English-speaking ability.

All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas and meet specific objectives established by the OCWCOG for providing services to low income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

Provide assurances that the Area Agency on Aging (AAA) will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with significant disabilities, with agencies that develop or provide services for individuals with disabilities.

Provide information and assurances concerning services to older individuals who are Native Americans, including:

A. Information concerning whether there is a significant population of older Native Americans in the planning and service area, and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under the Area Plan;

B. An assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides with services provided under Title VI of the Older Americans Act; and

C. An assurance that the Area Agency on Aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation, and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DHS. OCWCOG shall publicize the hearing(s) through legal notice, mailings, advertisements in the newspapers, and other methods determined by the AAA to be most effective in informing the public, service providers, advocacy groups, etc.

9·28·2012 — Date

Cynthia Solis — Executive Director, OCWCOG

9·28·2012 — Date

Catherine Stevens — Advisory Council Chair

9·28·2012 — Date

Cynthia Solis — Legal Contractor Authority

Executive Director — Title

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Attachments

Senior and Disability Services Acronyms

AAA - Area Agency on Aging
ADA - Americans with Disabilities ACT
ADL - Activities of Daily Living
ADRC- Aging and Disability Resource Connection
AIRS- Alliance of Information and Referral Systems
AOA- Administration on Aging
APD- Aging and People with Disabilities
APS- Adult Protective Services
ALF- Assisted Living Facility
AFH- Adult Foster Home
CBC- Community Based Care
CCO- Coordinated Care Organization
CDSMP- Chronic Disease Self Management Program
CMS- Centers for Medicare & Medicaid Services
CAN- Certified Nurses Assistant
COOP- Continuity of Operations Protocol
CSC- Community Services Consortium
DAS- Department of Administrative Services (State of Oregon)
DD- Developmental Disabilities
DHS- Department of Human Services (State of Oregon)
DSAC- Disability Services Advisory Council
FQHC- Federally Qualified Health Center
GA- General Assistance
HAC- Healthy Aging Coalition
HIPAA- Health Insurance Portability and Accountability Act
IADL- Instrumental Activities of Daily Living
IHN- Intercommunity Health Network
ILC- Independent Living Center

LCOG- Lane Council of Governments

LIHEAP- Low Income Home Energy Assistance Program

LTSS- Long Term Services and Supports

LWV- League of Woman Voters

MDS- Minimum Data Set

MDT- Multi-Disciplinary Team

MFP- Money Follow the Person

MOU- Memorandum of Understanding

MOW- Meals on Wheels

NAMI- National Alliance on Mental Illness

NASUA- National Association of State Units on Aging

NFCSP- National Family Caregivers Support Program

NWSDS- Northwest Senior and Disabled Services

OAA- Older Americans Act

O4AD- Oregon Association of Area Agencies on Aging and Disabilities

OC- Options Counselor

OCWCOG- Oregon Cascades West Council of Governments

OHP- Oregon Health Plan

OHSU- Oregon Health Sciences University

OPI- Oregon Project Independence

ORS- Oregon Revised Statutes

PEALS- Program to Encourage Active, Rewarding Lives for Seniors

PSA- Population Service Area

QA- Quality Assurance

RDAD- Reducing Disability in Alzheimer's Disease

RPI- Rapid Process Improvement

RSVP- Retired Senior Volunteers Program

SAGE- Service and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders

SART- Statistical Analysis of Rates and Trends
SCP- Senior Companion Program
SCSEP- Senior Community Service Employment Program
SEIU- State Employees International Union
SHIBA- Senior Health Insurance Benefits Assistance
SHS- Samaritan Health Services
SMAC- Senior Meals Advisory Committee
SNAP- Supplemental Nutrition Assistance Program
SNF- Skilled Nursing Facility
SNLH- Samaritan North Lincoln Hospital
SPD- Senior and People with Disabilities Division (State of Oregon)
SPL- Service Priority Level
SSAC- Senior Services Advisory Council
SSBG- Social Services Block Grant
SSDI- Social Security Disability Insurance
SSI- Supplemental Security Income
SSOC- Seniors Serving Oregon Coalition
STAR-C- Staff Training in Assisted-living Residences Caregivers
SUA- State Units on Aging
TANF- Temporary Assistance for Needy Families
VAST- Vulnerable Adult Services Team
VISTA- Volunteers In Service to America

Professional Services Contracts

OREGON CASCADES WEST COUNCIL OF GOVERNMENTS

PROFESSIONAL SERVICES CONTRACT

This is an agreement by and between OREGON CASCADES WEST COUNCIL OF GOVERNMENTS, an intergovernmental entity created under the authority of ORS 190.010, hereinafter called OCWCOG, and GRACE CENTER FOR ADULT DAY SERVICES an independent provider hereinafter called CONTRACTOR.

WHEREAS, OCWCOG has need for the services of a contractor with the particular training, ability, knowledge, and experience possessed by CONTRACTOR.

NOW, THEREFORE, in consideration of the mutual covenants contained herein the parties agree as follows:

1. TERM OF CONTRACT: This contract shall become effective upon signature, and shall terminate on JUNE 30, 2013.

2. SERVICES TO BE PROVIDED: CONTRACTOR shall provide adult day services under the OPI or Family Caregiver Support programs. OCWCOG will make referrals to CONTRACTOR with request for services as needed. This contract provides for daytime services including medication supervision, assistance with training in activities of daily living, and behavior management.

   Participants funded through Oregon Project Independence (OPI) will pay part of the cost of their care based on a sliding fee scale. OCWCOG will determine the fees to be paid by the participant, if any, and CONTRACTOR will collect fees and deduct them from their monthly billings.

   Due to the uncertain appropriations status for the OPI program, there will not be appropriations as of the date this contract is signed. If appropriations are received for the OPI program for 2012-2013, then the contract will be renegotiated at that time.

   Eligibility and Assessment

   1. The Case Manager shall evaluate the individual's eligibility and establish a service plan. OCWCOG will have no financial responsibility for individuals served until such time as a service plan has been developed, eligibility has been determined, and placement and payment have been authorized.
   2. Adult day services will be purchased for appropriate individuals who are eligible for OPI/ Family Caregiver Support services.
   3. The admission criteria for clients referred to the services:
      a. Ability to benefit from a social/psychological/nursing, restorative/rehabilitive plan of care;
      b. Must not require continuous bed bound nursing care;
      c. Must not be violent toward self or others;
      d. Must not require feeding through a gastrostomy or nasogastic tube;
      e. Must meet other admission criteria established by Grace Center for Adult Day Services and agreed to by OCWCOG.

   B. Referrals and Placement

      1. Referral of an individual for placement may be made when:
         a. The individual meets requirements of eligibility and admission criteria as set forth in section A.3.
         b. There is medical, nursing, social, and rehabilitation planning which can be carried out through this placement.
         c. OCWCOG Case Manager determines that the family caregiver is in need of respite from care giving.

d. Referrals for placement must be sent to the OCWCOG Program Manager who will then complete the referral to the program.

2. OCWCOG recognizes and respects CONTRACTOR's responsibility to determine whether a client meets their admission requirements and is accepted into the program. When placement of an eligible participant is to occur, a conference with the responsible Case Manager and program staff, and, when appropriate and feasible, the participant and/or participant's caregiver, will be arranged. The purpose of the conference is:
   a. To establish CONTRACTOR's role and responsibilities regarding the participant;
   b. To agree upon the participant's role and responsibilities, including the responsibility to apply resources towards the cost of care;
   c. To establish the Case Manager's role and responsibilities;
   d. To confirm planning to meet the individual care needs of the participant.
3. Clients will be terminated from the program when:
   a. The participant's condition changes to the point where his/her service/medical needs can no longer be met or services are no longer needed;
   b. The participant doesn't contribute their share of costs;
   c. The participant wishes to leave the program;
   d. The provider is not providing agreed upon services, or;
   e. The participant has observable behavior, which is deemed to be detrimental to self or other participants, beyond the ability to be safely managed by staff.

The termination procedure will include discussion between the Case Manager, CONTRACTOR's staff, participant (if feasible), and care givers, if any. The goal of the discussion will be to seek consultation from all parties that the service is no longer appropriate, cannot meet the needs of the participant, and/or to identify alternative resources in the community.

Written termination notices, confirming the date of termination, will be sent to the participant by the Case Manager or CONTRACTOR's staff upon determination that the services are no longer appropriate. The date of termination, reason for termination, and recommendations for alternative community resources will be included in the notice.

C. Responsibilities of Each Party

CONTRACTOR agrees to:

1. Provide staff, facilities, and equipment sufficient to perform the following services, as determined by the interdisciplinary team and recorded in the plan of care, and agreed upon for purchase by OCWCOG as individually determined:
2. Provide multi-dimensional assessment, including nursing evaluation, by an interdisciplinary team; develop and monitor a plan of care;
3. Assist with basic personal care, hygiene, grooming, and care of the hair;
4. Assistance with bladder and/or bowel requirements, including re-training, behavior management, and supervision as needed;
5. Assistance with medications ordered by the client's physician and over the counter medications;
6. Assistance with ambulation;
7. Assistance with adaptive equipment;
8. Assistance with behavioral problems, cognitive deficiencies, and other disorders associated with dementia and functional disorders;
9. Assistance with diet activities via a noon meal;

10. Provide appropriate non-skilled activities related to occupational, physical and speech therapy;
11. Provide planned activities suited to the needs of the participants and designed to encourage physical exercise, to prevent deterioration, and to stimulate social interaction as a part of the plan of care;
12. Provide social services including intake assessment; psychosocial support for participant and caregiver; case plan monitoring, and service coordination;
13. Provide other necessary assistance, re-training and support with activities of daily living.
14. Submit to OCWCOG by the 10th of each month, Program and Financial Report form, including names of all participants with appropriate case identification number and inclusive dates of service.
15. Assure coverage to meet required staffing by employing qualified and well-trained individuals.
16. Provide the name and phone number of administrative staff to OCWCOG.
17. Provide space and opportunity for the Case Managers to meet with participants in privacy.
18. Allow visits by other agencies as necessary to assure appropriate site for service delivery.
19. Notify the OCWCOG Case Manager of the need for a joint case review annually; or, when participant's condition changes significantly enough to require a change in the frequency of service; or, when a change in the service type is required.
20. Contact the OCWCOG Case Manager when a participant fails to use the program services on three previously scheduled appointments or when participant repeatedly does not utilize the services on pre-scheduled days.
21. Comply with pertinent regulations of other agencies.

OCWCOG agrees to:

1. Process referrals and facilitate placements of eligible participants.
2. Provide the program with necessary medical, social, and financial information on each participant.
3. Schedule regular, planned visits to program site to evaluate progress toward service and health care plan objectives; identify problems in carrying out the plans, and make any needed adjustment. Reviews should take place no less often than semi-annually.
4. Coordinate service planning and participate in required case staffing.
5. Maintain liaison with other agencies. Schedule interagency conferences as necessary to evaluate mutual efforts to provide services to individuals.
6. Assure that the services paid for by OCWCOG are consistent with the terms of the Contract; and inform CONTRACTOR of the reduction in, or termination of, payment for participants when services contractually agreed upon have not been provided.
7. Notify CONTRACTOR of any changes in agency policy, which affect individuals receiving services under the terms of this contract.
8. Provide CONTRACTOR with names and phone numbers of staff involved in service and eligibility determination.
9. Confirm the plan of care with CONTRACTOR and the participant by completing the appropriate forms.
10. Upon receipt of monthly billing statements from CONTRACTOR, pay the agreed upon hourly rate for all eligible and authorized OPI/Family Care Giver participants.

CONTRACTOR and OCWCOG Mutually Agree to:

1. Support and supplement one another's efforts in planning and providing services to meet the needs of the participants.
2. Schedule conferences as necessary with other health and social service agencies to evaluate the mutual services to an individual and make any modifications to the plan.
3. Work together as a team with the individual being served, CONTRACTOR's staff, other resource persons, and other persons who have a significant relationship to the individual. Evaluate the service objectives and modify them as increased understanding of the individual is gained.

3. PAYMENT: Payment will be made once a month within 15 days of OCWCOG's receipt of an invoice on the Program and Financial Report detailing services provided and after approval of the invoice by OCWCOG. Funding for the term of the contract shall not exceed $3,000 for the OPI program and $3,000 for the Family Care Giver program. OCWCOG agrees to pay CONTRACTOR $10.20 per hour per participant as payment in full, less any client income applied to cost. A minimum of six hours per day of Respite Care will be allocated and billed. This rate is to be paid after services are provided.

4. ASSIGNMENT/DELEGATION: Neither party shall assign, subcontract or transfer any interest in or duty under this agreement without the prior written consent of the other, and no assignment shall be of any force or effect whatsoever unless and until the other party has so consented.

5. STATUS OF CONTRACTOR: The parties intend that CONTRACTOR, in performing the services specified in this agreement, shall act as an independent contractor. Although OCWCOG reserves the right to (i) determine and modify the delivery schedule for work to be performed and (ii) evaluate the quality of the completed performance, only CONTRACTOR shall have the control of the work and the manner in which it is performed. CONTRACTOR is not to be considered an agent or employee of OCWCOG and is not entitled to participate in any pension plan, insurance, bonus, or similar benefits OCWCOG provides its employees.

   CONTRACTOR will not be eligible for any federal social security, state workers' compensation, unemployment insurance, or Public Employees Retirement System benefits from amounts paid under this contract, except as a self-employed individual.

   If this payment is to be charged against Federal funds, CONTRACTOR certifies that it is not currently employed by the Federal government and the amount charged does not exceed its normal charge for the type of service provided.

   OCWCOG will report the total amount of all payments to CONTRACTOR, including any expenses, in accordance with Federal Internal Revenue Service and State of Oregon Department of Revenue regulations. CONTRACTOR shall be responsible for any Federal or State taxes applicable to amounts paid under this contract.

6. WARRANTY: OCWCOG has relied upon representations by CONTRACTOR regarding its professional ability and training as a material inducement to enter into this contract. CONTRACTOR represents and warrants that all its work will be performed in accordance with generally accepted professional practices and standards as well as the requirements of applicable federal, state, and local laws, it being understood that acceptance of CONTRACTOR's work by OCWCOG shall not operate as a waiver or release of such warranty.

7. INDEMNIFICATION: CONTRACTOR shall hold harmless, indemnify, and defend OCWCOG, its officers, agents, and employees from any and all liability, actions, claims, losses, damages or other costs including attorney's fees and witness costs (at both trial and appeal level, whether or not a trial or appeal ever takes place) that may be asserted by any person or entity arising from, during or in connection with the performance of the work described in this contract, except liability arising out of the sole negligence of OCWCOG and its employees. Such indemnification shall also cover claims brought against OCWCOG under state or federal workers' compensation laws. If any aspect of this indemnity or the above warranty shall be found to be illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this indemnification or the above warranty.

8. INSURANCE: CONTRACTOR and any subcontractors shall maintain insurance acceptable to OCWCOG as provided in Attachment A. Such insurance shall remain in full force and effect throughout the term of this contract.

   If CONTRACTOR employs one or more workers as defined in ORS 656.027 and such workers are subject to the provisions of ORS Chapter 656, CONTRACTOR shall maintain currently valid workers' compensation insurance covering all such workers during the entire period of this contract.

9. METHOD AND PLACE OF GIVING NOTICE, SUBMITTING BILLS, AND MAKING PAYMENTS: All notices, bills and payments shall be made in writing and may be given by personal delivery or by mail. Notices, bills, and payments sent by mail should be addressed as follows:

   OCWCOG: Oregon Cascades West Council of Governments
   Attn: Finance
   1400 Queen Ave SE, Ste 201
   Albany, Oregon 97322 541-924-8467

   CONTRACTOR: Grace Center for Adult Day Services
   980 NW Spruce Ave
   Corvallis, OR 97330

   and when so addressed, shall be deemed given upon deposit in the United States Mail, postage prepaid. In all other instances, notices, bills, and payments shall be deemed given at the time of actual delivery. Changes may be made in the names and addresses of the person to whom notices, bills, and payments are to be given by giving notice pursuant to this paragraph.

10. TERMINATION: At any time, with or without cause, OCWCOG, in its sole discretion shall have the absolute right to terminate this agreement by giving written notice to CONTRACTOR. If OCWCOG terminates pursuant to this paragraph, CONTRACTOR shall be entitled to receive as full payment for all services satisfactorily rendered and expenses incurred, an amount which bears the same ratio to the total fees specified in the agreement as the services satisfactorily rendered by CONTRACTOR bear to the total services otherwise required to be performed for such total fee; provided, that there shall be deducted from such amount the amount of damage, if any, sustained by OCWCOG due to any breach of the agreement by CONTRACTOR.

11. OWNERSHIP OF WORK PRODUCT: OCWCOG shall be the owner of and shall be entitled to possession of all work products of CONTRACTOR that result from this contract ("the work products"). In addition, if any of the work products contain intellectual property of CONTRACTOR that is or could be protected by federal law, CONTRACTOR hereby grants OCWCOG a perpetual, royalty-free, fully paid, nonexclusive and irrevocable license to copy, reproduce, deliver, publish, perform, dispose of, use and re-use all such work products, including but not limited to databases, templates, file formats, scripts, links, procedures, materials, training manuals and other information, designs, plans or works provided or delivered to OCWCOG or produced by CONTRACTOR under this contract.

12. NONDISCRIMINATION: CONTRACTOR shall comply with all applicable federal, state and local laws, rules, and regulations on nondiscrimination in employment because of race, color, ancestry, national origin, religion, sex, marital status, age, medical condition, disability, sexual orientation, gender identity or source of income.

13. STATUTORY AND REGULATORY COMPLIANCE: CONTRACTOR shall comply with all federal, state and local laws, ordinances and regulations applicable to the work under this contract, including, without limitation, the applicable provisions of ORS chapter 279, particularly 279.312, 279.313, 279.314, 279.316 and 279.320, as amended. In addition, CONTRACTOR expressly agrees to comply with Title VI of the CIVIL RIGHTS ACT of 1964 and comparable state and local laws. CONTRACTOR shall also comply with Section V of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (Pub. Law No. 101-336), ORS 30.670 to ORS 30.685, ORS 659.425, ORS 659.430, and all regulations and administrative rules established pursuant to those laws.

14. EXTRA (CHANGED) WORK: Only the Program Director or authorized Deputy may authorize extra work (and/or changed) work. The parties expressly recognize that other OCWCOG personnel are not authorized to either order extra work (and/or changed) work or waive contract requirements. Failure of the CONTRACTOR to secure Program Director or authorized Deputy authorization for extra work shall constitute a waiver of any and all right to adjustment in the contract price or contract time due to such unauthorized extra work and the CONTRACTOR thereafter shall be entitled to no compensation whatsoever for the performance of such work.

    CONTRACTOR further expressly waives any and all right or remedy by way of restitution and quantum merit for any and all extra work performed by CONTRACTOR without the express and prior written authorization of the Program Director.

15. CONFLICT OF INTEREST: CONTRACTOR covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services. The CONTRACTOR further covenants that in the performance of this contract it shall not employ any person having any such interest.

16. AUDIT: CONTRACTOR shall maintain records to assure conformance with the terms and conditions of this agreement, and to assure adequate performance and accurate expenditures within the contract period. CONTRACTOR agrees to permit OCWCOG, the State of Oregon, the federal government, or their duly authorized representatives to audit all records pertaining to this agreement to assure the accurate expenditure of funds. CONTRACTOR shall notify OCWCOG of any independent audit report of CONTRACTOR'S activities or finances prepared for CONTRACTOR and agrees to submit such reports to the Finance Director upon request.

17. GOVERNING LAW: This contract shall be governed and construed by the laws of the State of Oregon.

18. SEVERABILITY: If any term or provision of this contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected.

19. MERGER: This writing and the attached exhibits constitute the entire and final contract between the parties. No modification of this agreement shall be effective unless and until it is made in writing and signed by both parties.

DATED this _____ day of _____, 2012.

GRACE CENTER FOR ADULT DAY SERVICES	OREGON CASCADES WEST COUNCIL OF GOVERNMENTS
Signature 7/16/12 Date	Cynthia Solie 6/26/12
	Cynthia Solie, Executive Director Date

EXHIBIT A

BUSINESS ASSOCIATE RELATIONSHIP

OCWCOG will make available and/or transfer to CONTRACTOR certain information, in conjunction with goods or services that are being provided by CONTRACTOR to OCWCOG that is confidential and must be afforded special treatment and protection.

CONTRACTOR will have access to and/or receive from OCWCOG certain information that can be used or disclosed only in accordance with this agreement and the HHS Privacy Regulations.

To the extent required by 42 U.S.C. 1171 *et seq.* enacted by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, CONTRACTOR assures OCWCOG that CONTRACTOR will appropriately safeguard protected health information made available to or obtained by CONTRACTOR.

CONTRACTOR further agrees to comply with applicable laws relating to protected health information and with respect to any task or other activity CONTRACTOR performs on behalf of OCWCOG, to the extent OCWCOG would be required to comply with such requirements.

For purposes of this agreement, the following terms shall apply:

A. CONTRACTOR shall be considered a BUSINESS ASSOCIATE;

B. OCWCOG shall be considered a COVERED ENTITY;

C. HHS Privacy Regulations shall mean the Code of Federal Regulations (C.F.R.) at Title 45, Sections 160 and 164;

D. Individual shall mean the person who is the subject of the information, and has the same meaning as the term 'individual' is defined by 45 C.F.R. 164.501; and

E. Secretary shall mean the Secretary of the Department of Health and Human Services (HHS) and any other officer or employee of HHS to whom the authority involved has been delegated;

F. Information shall mean any health information provided and/or made available by OCWCOG to CONTRACTOR, and has the same meaning as the term 'health information' as defined by 45 C.F.R. 160.102.

CONTRACTOR agrees it shall:

1. Not use or further disclose such information other than as permitted or required by this agreement. CONTRACTOR shall not, except as necessary for the proper management, administration and performance of its duties under this agreement, use, reproduce, disclose, or provide to third parties, any confidential document or information relating to OCWCOG or clients of OCWCOG without the prior written consent or authorization of OCWCOG or of the client. If CONTRACTOR uses such information for the purposes set forth above, it will only do so if the disclosure is required by law or CONTRACTOR obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which CONTRACTOR disclosed it to the person. CONTRACTOR shall ensure that its personnel, employees, affiliates and agents maintain the confidentiality of patient health information and business information of OCWCOG.

2. Not use or further disclose the information in a manner that would violate the requirements of applicable law, if done by OCWCOG;

3. Use appropriate safeguards to prevent use or disclosure of such information other than as provided for by this agreement;

4. Report to OCWCOG any use or disclosure of such information not provided for by this agreement of which CONTRACTOR becomes aware;

5. Ensure that any subcontractors or agents to whom CONTRACTOR provides protected health information received from OCWCOG agree to the same restrictions and conditions that apply to CONTRACTOR with respect to such information;

6. Make available protected health information in accordance with applicable law, i.e., the Code of Federal Regulations (C.F.R.) at Title 45, Sections 160 and 164;

7. Maintain standard records, pursuant to this agreement, and to provide such records and other necessary information to OCWCOG as may be requested in writing and as permitted by law. CONTRACTOR agrees that all records kept in connection with this agreement are subject to review and audit by OCWCOG upon reasonable notice of a minimum of 14 workdays from the date of written request by OCWCOG.

8. Make CONTRACTOR'S internal practices, books, and records relating to the use and disclosure of protected health information received from OCWCOG available to the Secretary of the United States Health & Human Services for purposes of determining OCWCOG's compliance with applicable law (in all events, CONTRACTOR shall immediately notify OCWCOG upon receipt by CONTRACTOR of any such request, and shall provide OCWCOG with copies of any such materials);

9. Hold harmless, indemnify and defend OCWCOG from any claim, suit, action, fine or penalty of any type whatsoever based in whole or in part on CONTRACTOR'S failure to comply with applicable laws protecting covered health information.

10. Upon termination of this agreement, CONTRACTOR shall promptly return all protected health information received from OCWCOG. If the return of protected health information is not feasible, CONTRACTOR shall continue the protections required under this contract to the protected health information consistent with the requirements of this Attachment and the HIPAA privacy standards.

ATTACHMENT A

INSURANCE REQUIREMENTS

The CONTRACTOR and its subcontractors shall maintain insurance acceptable to OCWCOG in full force and effect throughout the term of this contract.

It is agreed that any insurance maintained by OCWCOG shall apply in excess of, and not contribute with, insurance provided by CONTRACTOR. The policy or policies of insurance maintained by the CONTRACTOR and its subcontractors shall provide at least the following limits and coverages.

TYPE OF INSURANCE		LIMITS OF LIABILITY
☒ General Liability	Each Occurrence	$500,000
	General Aggregate	$500,000
	Products/Comp Ops Aggregate	$500,000
	Personal and Advert. Inj.	$500,000
☐ Automobile Liability	Combined Single covering any vehicle used on OCWCOG business	$500,000
	OR	
	Bodily Injury:	
	Per person	$200,000
	Per occurrence	$500,000
	Property Damage:	
	Per occurrence	$ 50,000
☒ Worker's Compensation	Per Oregon State Statutes	
☒ Professional Liability	Per occurrence	$500,000
	Annual aggregate	$500,000
☐ Property of Others in Transit (If Contractor to haul equipment)		$250,000

CONTRACTOR'S general liability must be evidenced by a certificate from the insurer. The policy(s) shall name Oregon Cascades West Council of Governments, its officers, agents and employees as additional insureds and shall provide Oregon Cascades West Council of Governments with a 30-day notice of cancellation.

Worker's compensation insurance must be evidenced by a certificate from the insurer. The certificate need not name Oregon Cascades West Council of Governments as an additional insured, but must list Oregon Cascades West Council of Governments as a certificate holder and provide a 30-day notice of cancellation to Oregon Cascades West Council of Governments.

Certificates of Insurance shall be forwarded to:

Oregon Cascades West Council of Governments
Finance Dept
1400 Queen Ave SE, Ste 201
Albany, OR 97322

CONTRACTOR agrees to deposit with OCWCOG, at the time she/he returns the executed contract, Certificates of Insurance or Binders of Insurance if the policy is new or has expired, sufficient to satisfy OCWCOG that the insurance provisions of this contract have been complied with and to keep such insurance in effect and the certificates and/or binders thereof on deposit with OCWCOG during the entire term of this contract. Such certificates and/or binders must be delivered prior to commencement of the work.

The procuring of such required insurance shall not be construed to limit CONTRACTOR'S liability hereunder. Notwithstanding said insurance, CONTRACTOR shall be obligated for the total amount of any damage, injury or loss caused by negligence or neglect connected with this contract.

PROGRAM AND FINANCIAL REPORT
GRACE CENTER FOR ADULT DAY SERVICES
OPI PROGRAM
980 NW Spruce Ave, Corvallis, OR 97330

For the Month of _____, _____

CLIENT NAME	# of hours this month	# of hours year to date	Cost Year to Date
Total			

Hours of Service _____ X $10.20= $_____

Less Client Fees_____ =$_____

Total Due =$_____

_____
Contractor's Signature Date

_____
Finance Director, OCWCOG Date

PROGRAM AND FINANCIAL REPORT
GRACE CENTER FOR ADULT DAY SERVICES
FAMILY CARE GIVER PROGRAM
980 NW Spruce Ave, Corvallis, OR 97330

For the Month of _____, _____.

CLIENT NAME	# of days this month	# of days year to date	Cost Year to Date
Total			

Full Days of Service _____ X $78.00 = $_____

Half Days of Service (no lunch) _____ X $41.00 = $_____

Less Client Fees _____ =$_____

Total Due =$_____

_____

Contractor's Printed Name & Signature Date

_____

Finance Director, OCWCOG Date

Reports are due by the 10th of each month to:
Finance Director
Finance Department
1400 Queen Ave SE, Ste 206
Albany, OR 97322

OREGON CASCADES WEST COUNCIL OF GOVERNMENTS

PROFESSIONAL SERVICES CONTRACT

This is an agreement by and between OREGON CASCADES WEST COUNCIL OF GOVERNMENTS, an intergovernmental entity created under the authority of ORS 190.010, hereinafter called OCWCOG, and LEGAL AID SERVICES OF OREGON, hereinafter called CONTRACTOR.

WHEREAS, OCWCOG has need for the services of individuals with the particular training, ability, knowledge, and experience possessed by CONTRACTOR.

NOW, THEREFORE, in consideration of the mutual covenants contained herein the parties agree as follows:

1. TERM OF CONTRACT. This contract shall become effective upon signature, and shall terminate on June 30, 2013.

2. SERVICES TO BE PROVIDED. CONTRACTOR shall provide up to 400 hours of legal services to persons 60 years of age and older in Linn, Benton and Lincoln counties. Two part-time attorneys will provide services to clients age 60 and over residing in Linn, Benton, and Lincoln counties. Clients will call Legal Aid Services of Oregon to make appointments with an attorney. Collect calls will be accepted. Client appointments will be scheduled for one day every month at senior centers in Sweet Home, Albany, Lebanon, and Corvallis. In Lincoln County appointments will be made at the Newport office of Legal Aid Services of Oregon or at the client's home, if traveling to Newport is not appropriate. Appointments will also be scheduled at the Albany office of Legal Aid Services of Oregon, in client's homes, at nursing homes, or telephone appointments as necessary.

CONTRACTOR will be responsible for publicizing the program by various means including, but not limited to:

A. Updating and distributing brochures;

B. Release of news articles to community newspapers, Generations, and Senior News;

C. Presentations to professional and lay groups regarding the services available to seniors under this contract.

Appropriate referrals will be made to pro bono volunteer attorneys currently operating in the counties. Such referrals will be to take advantage of professional expertise of volunteer attorneys in areas of law not frequently handled by the staff attorney. These referrals will be for the benefit of low-income seniors only.

OBJECTIVES: CONTRACTOR will provide legal services to approximately 42 individual clients with separate legal problems which will include client services having an impact beyond their individual case. CONTRACTOR will provide up to 20 hours of Senior Services staff and Ombudsman consultation services for Designated Staff and participation on the Vulnerable Adult Services Team on Elder Abuse. A significant number of additional hours will be provided for outreach and community educational committee jobs. CONTRACTOR will include information regarding Senior Law Programs at all community out reach activities and will continue to develop community education materials as appropriate.

CLIENT EVALUATION: Every client will be given an evaluation form to complete. CONTRACTOR will complete a summary report for the OCWCOG review prior to the annual assessment in early 2012 and at the end of the fiscal year.

REPORTING REQUIREMENTS: CONTRACTOR will submit monthly progress and fiscal reports to OCWCOG by the tenth (10th) of the following month. OCWCOG will provide the report forms for these reports. In addition to these monthly reports, CONTRACTOR will also submit quarterly reports describing the types of services being provided by the attorneys. Quarterly reports will be submitted to OCWCOG by the 15th of October 2012, January, April and July of 2013.

INTAKE PROCESS: Requests for services to seniors will be made by calling the Legal Services office in Albany for Linn and Benton counties, and in Newport for Lincoln County, and requesting an appointment.

Intake sites for Linn and Benton counties are senior centers in Sweet Home, Lebanon, Albany and Corvallis. For Linn and Benton counties, the CONTRACTOR will provide monthly intake for three clients at each site. Intake may be provided via telephone as often as every other month. CONTRACTOR will take special care to assure that clients who are unable to communicate adequately by phone will be seen in person at their homes or at an intake

site. For Lincoln County, the CONTRACTOR will see a total of four clients per month at the Newport office of CONTRACTOR, or at the client's home if traveling to Newport is not appropriate.

IMPACT WORK: Self-help packets and brochures will be provided or mailed to appropriate applicants and will be made available to OCWCOG staff. They will contain information, instructions and/or forms regarding judgment-proof consumer collections, Advanced Directives, Wills, Powers of Attorney, Small Claims Court, pro bono attorneys, Medicaid and Long-Term Care.

PROJECTS: Impact project areas will be selected by the CONTRACTOR based on areas of need discovered through their representation of individual clients. The CONTRACTOR attorneys will submit an explanatory memorandum, describing the project and its impact. The CONTRACTOR WILL provide a progress report during the six-month review for each project in progress or completed during the previous six months.

SERVICE PRIORITIES: Legal services shall be targeted to the most vulnerable older persons to protect their health, welfare, independence, and security. These services should be those which are most needed and least available from other sources. The following service categories are listed in priority order:

Category 1
- Rights of nursing home, adult foster home and other congregate care facility residents
- Rights of Medicaid and Supplemental Security Income applicants and recipients
- Defense of guardianship and conservatorship

Category 2
- Prevention and rectification of financial, physical and/or emotional abuse
- Rights of tenants, prevention of housing discrimination
- Rights of applicants for and borrowers under FHA, FMHA and VA loans
- Rights of utility consumers

Category 3
- Issues related to Medicaid, food stamps, Social Security and other public benefits
- Unfair debt collection practices
- Disability and age discrimination in employment

Special cases, which are appropriate, and do not fall into any of the above categories will be served on a case-by-case basis. The above priorities do not necessarily reflect historical or anticipated service levels.

CONTRACTOR'S income guidelines are 125% of poverty level or if high medical bills, 185% of poverty level. Legal Aid Services of Oregon do not have income restrictions but services are targeted to elderly with greatest social and economic need.

OCWCOG Agrees To:

A. Refer appropriate clients for service.
B. Monitor and assess the service under this contract through review of monthly program and financial reports, periodic consultation with supervisor, and observation of operations.
C. Interpret applicable program standards, regulations and procedures.
D. Review financial records and determine that all charges against this contract are in accordance with this contract and applicable federal and/or state regulations.
E. Compile appropriate program and financial records and submit reports to Senior and Disabled Services Division.

3. PAYMENT: OCWCOG will finance the services at a rate of $75.00 per hour, expenditures shall not exceed $30,000 ($23,927 from Older American Act money and $6,073 from Legal Aid Services of Oregon revenue). Any funds not obligated as of the last day of this contract and not expended within 60 days thereafter, shall be returned to OCWCOG. CONTRACTOR will submit monthly billings on the PROGRAM AND FINANCIAL REPORT to OCWCOG by the 10th of the following month, for authorization and processing for payment.

4. ASSIGNMENT/DELEGATION: Neither party shall assign, subcontract or transfer any interest in or duty under this agreement without the prior written consent of the other, and no assignment shall be of any force or effect whatsoever unless and until the other party has so consented.

5. STATUS OF CONTRACTOR: The parties intend that CONTRACTOR, in performing the services specified in this agreement, shall act as an independent contractor. Although OCWCOG reserves the right to (i) determine and modify the delivery schedule for work to be performed and (ii) evaluate the quality of the completed performance, only CONTRACTOR shall have the control of the work and the manner in which it is performed. CONTRACTOR is not to be considered an agent or employee of OCWCOG and is not entitled to participate in any pension plan, insurance, bonus, or similar benefits OCWCOG provides its employees.

CONTRACTOR will not be eligible for any Federal social security, State workers' compensation, unemployment insurance, or Public Employees Retirement System benefits from amounts paid under this contract, except as a self-employed individual.

If this payment is to be charged against Federal funds, CONTRACTOR certifies that it is not currently employed by the Federal government and the amount charged does not exceed its normal charge for the type of service provided.

OCWCOG will report the total amount of all payments to CONTRACTOR, including any expenses, in accordance with Federal Internal Revenue Service and State of Oregon Department of Revenue regulations. CONTRACTOR shall be responsible for any Federal or State taxes applicable to amounts paid under this contract.

6. WARRANTY: OCWCOG has relied upon representations by CONTRACTOR regarding its professional ability and training as a material inducement to enter into this contract. CONTRACTOR represents and warrants that all its work will be performed in accordance with generally accepted professional practices and standards as well as the requirements of applicable Federal, State, and local laws, it being understood that acceptance of CONTRACTOR's work by OCWCOG shall not operate as a waiver or release of such warranty.

7. INDEMNIFICATION: CONTRACTOR shall hold harmless, indemnify, and defend OCWCOG, its officers, agents, and employees from any and all liability, actions, claims, losses, damages or other costs including attorney's fees and witness costs (at both trial and appeal level, whether or not a trial or appeal ever takes place) that may be asserted by any person or entity arising from, during or in connection with the performance of the work described in this contract, except liability arising out of the sole negligence of OCWCOG and its employees. Such indemnification shall also cover claims brought against OCWCOG under state or federal workers' compensation laws. If any aspect of this indemnity or the above warranty shall be found to be illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this indemnification or the above warranty.

8. INSURANCE: CONTRACTOR and any subcontractors shall maintain insurance acceptable to OCWCOG as provided in Attachment A. Such insurance shall remain in full force and effect throughout the term of this contract.

If CONTRACTOR employs one or more workers as defined in ORS 656.027 and such workers are subject to the provisions of ORS Chapter 656, CONTRACTOR shall maintain currently valid workers' compensation insurance covering all such workers during the entire period of this contract.

9. METHOD AND PLACE OF GIVING NOTICE, SUBMITTING BILLS, AND MAKING PAYMENTS: All notices, bills and payments shall be made in writing and may be given by personal delivery or by mail. Notices, bills, and payments sent by mail should be addressed as follows:

OCWCOG: Oregon Cascades West Council of Governments
Attn: Finance
1400 Queen Ave SE, Ste 201
Albany, Oregon 97322
541-924-8467

CONTRACTOR: Mitzi Naucler, Regional Director
Legal Aid Services of Oregon
433 SW 4th
Albany, Oregon 97321

and when so addressed, shall be deemed given upon deposit in the United States Mail, postage prepaid. In all other instances, notices, bills, and payments shall be deemed given at the time of actual delivery. Changes may be made in the names and addresses of the person to whom notices, bills, and payments are to be given by giving notice pursuant to this paragraph.

10. TERMINATION: At any time, with or without cause, OCWCOG, in its sole discretion shall have the absolute right to terminate this agreement by giving written notice to CONTRACTOR. If OCWCOG terminates pursuant to this paragraph, CONTRACTOR shall be entitled to receive as full payment for all services satisfactorily rendered and expenses incurred, an amount which bears the same ratio to the total fees specified in the agreement as the services satisfactorily rendered by CONTRACTOR bear to the total services otherwise required to be performed for such total fee; provided, that there shall be deducted from such amount the amount of damage, if any, sustained by OCWCOG due to any breach of the agreement by CONTRACTOR.

11. OWNERSHIP OF WORK PRODUCT: OCWCOG shall be the owner of and shall be entitled to possession of all work products of CONTRACTOR that result from this contract ("the work products"). In addition, if any of the work products contain intellectual property of CONTRACTOR that is or could be protected by federal law, CONTRACTOR hereby grants OCWCOG a perpetual, royalty-free, fully paid, nonexclusive and irrevocable license to copy, reproduce, deliver, publish, perform, dispose of, use and re-use all such work products, including but not limited to databases, templates, file formats, scripts, links, procedures, materials, training manuals and other information, designs, plans or works provided or delivered to OCWCOG or produced by CONTRACTOR under this contract.

12. NONDISCRIMINATION: CONTRACTOR shall comply with all applicable Federal, State and local laws, rules, and regulations on nondiscrimination in employment because of race, color, ancestry, national origin, religion, sex, marital status, age, medical condition, disability, sexual orientation, gender identity or source of income.

13. STATUTORY AND REGULATORY COMPLIANCE: CONTRACTOR shall comply with all Federal, State and local laws, ordinances and regulations applicable to the work under this contract, including, without limitation, the applicable provisions of ORS chapter 279, particularly 279.312, 279.313, 279.314, 279.316 and 279.320, as amended. In addition, CONTRACTOR expressly agrees to comply with Title VI of the CIVIL RIGHTS ACT of 1964 and comparable State and local laws. CONTRACTOR shall also comply with Section V of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (Pub. Law No. 101-336), ORS 30.670 to ORS 30.685, ORS 659.425, ORS 659.430, and all regulations and administrative rules established pursuant to those laws.

14. EXTRA (CHANGED) WORK: Only the Program Director or authorized Deputy may authorize extra work (and/or changed) work. The parties expressly recognize that other OCWCOG personnel are not authorized to either order extra work (and/or changed) work or waive contract requirements. Failure of the CONTRACTOR to secure Program Director or authorized Deputy authorization for extra work shall constitute a waiver of any and all right to adjustment in the contract price or contract time due to such unauthorized extra work and the CONTRACTOR thereafter shall be entitled to no compensation whatsoever for the performance of such work.

CONTRACTOR further expressly waives any and all right or remedy by way of restitution and quantum merit for any and all extra work performed by CONTRACTOR without the express and prior written authorization of the Program Director.

15. CONFLICT OF INTEREST: CONTRACTOR covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services. The CONTRACTOR further covenants that in the performance of this contract it shall not employ any person having any such interest.

16. AUDIT: CONTRACTOR shall maintain all fiscal records relating to this contract in accordance with generally accepted accounting principles to assure conformance with the terms and conditions of this agreement, and to assure adequate performance and accurate expenditures within the contract period. CONTRACTOR agrees to permit OCWCOG, the State of Oregon, the federal government, or their duly authorized representatives to audit all records pertaining to this agreement to assure the accurate expenditure of funds. CONTRACTOR shall notify OCWCOG of any independent audit report of CONTRACTOR'S activities or finances prepared for CONTRACTOR and agrees to submit such reports to the Finance Director upon request.

17. GOVERNING LAW: This contract shall be governed and construed by the laws of the State of Oregon.

18. SEVERABILITY: If any term or provision of this contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected.

19. MERGER: This writing and the attached exhibits constitute the entire and final contract between the parties. No modification of this agreement shall be effective unless and until it is made in writing and signed by both parties.

DATED this _____ day of _____, 2012.

7/2/12
Mitzi Naucler, Regional Director Date
Legal Aid Services of Oregon

6/26/12
Cynthia Sollie, Executive Director Date
Oregon Cascades West Council of Governments

ATTACHMENT A

INSURANCE REQUIREMENTS

The CONTRACTOR and its subcontractors shall maintain insurance acceptable to OCWCOG in full force and effect throughout the term of this contract.

It is agreed that any insurance maintained by OCWCOG shall apply in excess of, and not contribute with, insurance provided by CONTRACTOR. The policy or policies of insurance maintained by the CONTRACTOR and its subcontractors shall provide at least the following limits and coverages:

TYPE OF INSURANCE		LIMITS OF LIABILITY
☒ General Liability	Each Occurrence	$500,000
	General Aggregate	$500,000
	Products/Comp Ops Aggregate	$500,000
	Personal and Advert. Inj	$500,000
Please indicate if Claims Made or Occurrence		
☐ Automobile Liability	Combined Single covering any vehicle used on OCWCOG business	$500,000
	OR	
	Bodily Injury:	
	Per person	$200,000
	Per occurrence	$500,000
	Property Damage:	
	Per occurrence	$ 50,000
☒ Worker's Compensation	Per Oregon State Statutes	
☒ Professional Liability	Per occurrence	$500,000
	Annual aggregate	$500,000
☐ Property of Others in Transit (If Contractor to haul OCWCOG Equipment)		$250,000

CONTRACTOR'S general liability and automobile insurance must be evidenced by certificates from the insurers. The policies shall name Oregon Cascades West Council of Governments, its officers, agents and employees as additional insureds and shall provide Oregon Cascades West Council of Governments with a 30-day notice of cancellation.

Worker's compensation insurance must be evidenced by a certificate from the insurer. The certificate need not name Oregon Cascades West Council of Governments as an additional insured, but must list Oregon Cascades West Council of Governments as a certificate holder and provide a 30-day notice of cancellation to Oregon Cascades West Council of Governments.

Certificates of Insurance shall be forwarded to:

Oregon Cascades West Council of Governments
Finance Dept
1400 Queen Ave SE, Ste 201
Albany, OR 97322

CONTRACTOR agrees to deposit with OCWCOG, at the time she/he returns the executed contract, Certificates of Insurance or Binders of Insurance if the policy is new or has expired, sufficient to satisfy OCWCOG that the insurance provisions of this contract have been complied with and to keep such insurance in effect and the certificates and/or binders thereof on deposit with OCWCOG during the entire term of this contract. Such certificates and/or binders must be delivered prior to commencement of the work.

The procuring of such required insurance shall not be construed to limit CONTRACTOR'S liability hereunder. Notwithstanding said insurance, CONTRACTOR shall be obligated for the total amount of any damage, injury or loss caused by negligence or neglect connected with this contract.

Contractor Invoice

For Services Performed for

Oregon Cascades West Council of Governments

Please submit this invoice at the beginning of each month for the previous quarter's work. Include a monthly report of the activities accomplished under your contract with Oregon Cascades West Council of Governments.

Contractor Name: _____

Contractor Mailing Address: _____
Street Address

_____
City State Zip

Contract Name/Number: _____

For Time Period: From _____ To _____

Amount Due: _____

Signed: _____

Date: _____

Comments:

EXHIBIT A

BUSINESS ASSOCIATE RELATIONSHIP

OCWCOG will make available and/or transfer to CONTRACTOR certain information, in conjunction with goods or services that are being provided by CONTRACTOR to OCWCOG that is confidential and must be afforded special treatment and protection.

CONTRACTOR will have access to and/or receive from OCWCOG certain information that can be used or disclosed only in accordance with this agreement and the HHS Privacy Regulations.

To the extent required by 42 U.S.C. 1171 *et seq.* enacted by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, CONTRACTOR assures OCWCOG that CONTRACTOR will appropriately safeguard protected health information made available to or obtained by CONTRACTOR.

CONTRACTOR further agrees to comply with applicable laws relating to protected health information and with respect to any task or other activity CONTRACTOR performs on behalf of OCWCOG, to the extent OCWCOG would be required to comply with such requirements.

For purposes of this agreement, the following terms shall apply:

A. CONTRACTOR shall be considered a BUSINESS ASSOCIATE;

B. OCWCOG shall be considered a COVERED ENTITY;

C. HHS Privacy Regulations shall mean the Code of Federal Regulations (C.F.R.) at Title 45, Sections 160 and 164;

D. Individual shall mean the person who is the subject of the information, and has the same meaning as the term "individual" is defined by 45 C.F.R. 164.501; and

E. Secretary shall mean the Secretary of the Department of Health and Human Services (HHS) and any other officer or employee of HHS to whom the authority involved has been delegated;

F. Information shall mean any health information provided and/or made available by OCWCOG to CONTRACTOR, and has the same meaning as the term "health information" as defined by 45 C.F.R. 160.102.

CONTRACTOR agrees it shall:

1. Not use or further disclose such information other than as permitted or required by this agreement. CONTRACTOR shall not, except as necessary for the proper management, administration and performance of its duties under this agreement, use, reproduce, disclose, or provide to third parties, any confidential document or information relating to OCWCOG or clients of OCWCOG without the prior written consent or authorization of OCWCOG or of the client. If CONTRACTOR uses such information for the purposes set forth above, it will only do so if the disclosure is required by law or CONTRACTOR obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which CONTRACTOR disclosed it to the person. CONTRACTOR shall ensure that its personnel, employees, affiliates and agents maintain the confidentiality of patient health information and business information of OCWCOG.

2. Not use or further disclose the information in a manner that would violate the requirements of applicable law, if done by OCWCOG;

3. Use appropriate safeguards to prevent use or disclosure of such information other than as provided for by this agreement;

4. Report to OCWCOG any use or disclosure of such information not provided for by this agreement of which CONTRACTOR becomes aware;

5. Ensure that any subcontractors or agents to whom CONTRACTOR provides protected health information received from OCWCOG agree to the same restrictions and conditions that apply to CONTRACTOR with respect to such information;

6. Make available protected health information in accordance with applicable law, i.e., the Code of Federal Regulations (C.F.R.) at Title 45, Sections 160 and 164;

7. Maintain standard records, pursuant to this agreement, and to provide such records and other necessary information to OCWCOG as may be requested in writing and as permitted by law. CONTRACTOR agrees that all records kept in connection with this agreement are subject to review and audit by OCWCOG upon reasonable notice of a minimum of 14 workdays from the date of written request by OCWCOG.

8. Make CONTRACTOR'S internal practices, books, and records relating to the use and disclosure of protected health information received from OCWCOG available to the Secretary of the United States Health & Human Services for purposes of determining OCWCOG's compliance with applicable law (in all events, CONTRACTOR shall immediately notify OCWCOG upon receipt by CONTRACTOR of any such request, and shall provide OCWCOG with copies of any such materials);

9. Hold harmless, indemnify and defend OCWCOG from any claim, suit, action, fine or penalty of any type whatsoever based in whole or in part on CONTRACTOR'S failure to comply with applicable laws protecting covered health information.

10. Upon termination of this agreement, CONTRACTOR shall promptly return all protected health information received from OCWCOG. If the return of protected health information is not feasible, CONTRACTOR shall continue the protections required under this contract to the protected health information consistent with the requirements of this Attachment and the HIPAA privacy standards.

Exhibit B

OREGON CASCADES WEST COUNCIL OF GOVERNMENTS – SENIOR SERVICES FINANCIAL REPORT

Program/Activity: Legal Services Reporting Agency: Legal Aid Services of Oregon Month/Year _____ FY2012-2013

LINE ITEM	OCWCOG BUDGET	THIS MONTH	YEAR TO DATE	%	MATCH BUDGET	THIS MONTH	YEAR TO DATE	%	TOTAL BUDGET	TOTAL EXPEND
PERSONNEL & FRINGE	$23,763				$4,063				$27,746	
TELEPHONE					$616				$616	
SUPPLIES					$134				$134	
PRINTING/DUPLICATES					$154				$154	
POSTAGE					$107				$107	
BAR (BUSINESS/PRACTICE)	$124				$469				$641	
TRAVEL (STATE)	$ 00				$426				$526	
TRAINING/CONFERENCE					$154				$154	
TOTAL	$23,887				$6,093				$30,080	
DONATIONS										

Total YTD Expenditures: $_____

Donations this month: $_____

Donations YTD: $_____

Clients Served (unduplicated YTD): _____

Cost per Client: $_____

Number of Units of Service (YTD): _____

Cost Per Unit: $_____

Legal Services Director Date OCWCOG Program Manager Date OCWCOG Accountant Date

Exhibit C

OREGON CASCADES WEST COUNCIL OF GOVERNMENTS
SENIOR SERVICES

CONTRACTING AGENCY: Oregon Legal Services PROGRAM/ACTIVITY: Senior Law Service BUDGET PERIOD: 2012-2013

ITEM	OAA	CASH MATCH	SOURCE	TOTAL
Personnel	$20,421	$2,252 $500	United Way Legal Services Corp (LSC)	$23,223
Fringe Benefits	$3,282	$1,241	LSC	$4,523
Telephone		$616	LSC	$616
Supplies		$154	LSC	$154
Print/Dup		$154	LSC	$154
Postage		$107	LSC	$107
Travel	$100	$426	LSC	$526
Training		$154		$154
Bar Dues/Malpractice	$124	$419	LSC	$543
Total	$23,927	$6,073		$30,000

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SHIBA SUBGRANTEE AGREEMENT Agreement # SHIBA1213-11

This agreement is between **Oregon Cascades West Council of Governments/Lincoln County RSVP** (hereinafter referred to as Subgrantee) and the **Senior Health Insurance Benefits Assistance (SHIBA) Program of the Department of Consumer and Business Services (hereinafter referred to as SHIBA)** for the local implementation and delivery of the federal State Health Insurance Assistance Program (SHIP) grant (CFDA 93.779). The Subgrantee will be part of Oregon's effort to strengthen its capability to provide all Medicare eligible individuals information, counseling and assistance on health insurance matters. This Agreement is 100% funded with Federal funds. The Contract Administrators of this Agreement are:

SHIBA	Oregon Cascades West Council of Governments/Lincoln County RSVP
Contract Administrator: Lisa Emerson Title: SHIBA Program Manager State of Oregon, Department of Consumer and Business Services, SHIBA 350 Winter Street SE P.O. Box 14480 Salem, OR 97309-0405 Phone: 503-947-7087 Fax: 503-947-7092 Email: lisa.emerson@state.or.us	Contract Administrator: Tamara Rosser Title: RSVP Director/SHIBA Coordinator Lincoln County RSVP 203 N Main ST Toledo, OR 97391 Phone: 541-574-2684 Fax: 541-574-2689 FEIN: 93-6002304 Email: trosser@ocwcog.org Main Office: Oregon Cascades West Council of Governments 1400 Queen Ave SE STE 201 Albany, OR 97322 FEIN 93-0584306

I. PURPOSE:

The State Health Insurance Assistance Program (SHIP) grant is intended to strengthen the capability of States to provide all Medicare eligible individuals information, counseling, and assistance on health insurance matters. This federal grant from the Centers for Medicare & Medicaid Services (CMS) helps ensure that States have a network of staff and volunteers to provide accurate and objective health insurance information and assistance in making informed health coverage decisions and understanding related rights and protections. Although States have adopted a variety of methods to provide such

services to individuals. Section 4360 of the Omnibus Budget Reconciliation Act of 1990 requires that each State program must encompass particular activities.

Objectives:

1. Subgrantee will provide personalized counseling to an increasing number and diversity of individual beneficiaries unable to access other channels of information or needing and preferring locally-based individual counseling services.
2. Subgrantee will conduct targeted community outreach to beneficiaries in public forums either under their sponsorship or with community-based partners or coalitions to increase understanding of Medicare program benefits and raise awareness of the opportunities for assistance with benefit and plan selection.
3. Subgrantee will increase and enhance beneficiary access to a counselor work force that is trained, certified and fully equipped and proficient in providing the full range of services including enrollment assistance in appropriate benefit plans, and continued enrollment assistance in prescription drug coverage.
4. Subgrantee will participate in CMS education and communication activities, as required by SHIBA, to assure that SHIP counselors are equipped to respond to both Medicare program updates and a rapidly changing counseling environment and to provide CMS with information about the support and resources that SHIPs need to provide accurate and reliable counseling services.

II. TERM OF AGREEMENT

This Agreement shall become effective on the date at which every party has signed this Agreement. This Agreement shall expire on **March 31, 2013** unless amended, terminated early in accordance with section VI, or if funds are no longer available.

III. STATEMENT OF WORK

The Subgrantee shall:

1. Provide counseling and assistance to Medicare eligible individuals in need of health insurance information including:

a. Information that may assist individuals in obtaining benefits and filing claims under Titles XVIII and XIX of the Social Security Act.
b. Policy comparison information for Medicare supplemental policies (as described in section 1882(g)(1) of the Social Security Act, as amended) and information that may assist eligible individuals with filing claims under such Medicare supplemental policies.
c. Information regarding long-term care insurance.
d. Information regarding Medicaid programs, including Medicare Savings Programs.
e. Information regarding other types of health insurance benefits that may be provided to eligible individuals in the State.
f. Information regarding all Medicare health insurance coverage options.

2. Conduct outreach programs to provide health insurance information, counseling and assistance to eligible individuals, including an emphasis on reaching vulnerable, isolated and non-English speaking seniors. In achieving these efforts, the Subgrantee shall:
   a. Provide counseling to a greater number of individual beneficiaries unable to access other channels of information or needing and preferring locally-based individual counseling services.
   b. Create more counseling resources and locations that are locally accessible to low-income, dual eligible, and hard-to reach beneficiaries, including rural communities.
   c. Increase targeted outreach in order to provide access to counseling to low-income, dual-eligible, and hard-to-reach populations.
   d. Provide educational materials as necessary to assist in achieving these standards.

3. Develop systems of referral to appropriate Federal or State departments or agencies that provide assistance with problems related to health insurance coverage (including legal problems).

4. Assure full accessibility of SHIBA services to all categories of Medicare eligible individuals, including the aged, disabled, and end stage renal disease patients. SHIBA services are to be provided without discrimination on the basis of race, color, national origin, disability, age, sex, or income. Reasonable efforts must also be made to accommodate eligible individuals with existing barriers that limit their access to information, e.g. language, visual, hearing or speech impairments, physical accessibility, literacy, and location.

5. Establish a sufficient number of staff positions (including volunteers) necessary to provide the services of a health insurance information, counseling and assistance program.

6. Request, as necessary, federal Unique Identifiers for staff and volunteers through state SHIBA office. Maintain copies of signed confidentiality agreements for individually assigned Unique IDs.

7. Assure that local SHIBA staff and volunteers have no conflict of interest in providing health insurance information, counseling and assistance, and agree to abide by the SHIBA Confidentiality and Conflict of Interest policy for safeguarding confidential beneficiary information.

8. Collect and disseminate timely and accurate health insurance information to staff members (including volunteers).

9. Utilize state and federal training program materials as part of the training program for staff members (including volunteers). Conduct a certification review to ensure staff and volunteers are trained in accordance with their job duties. Conduct continuing

education to ensure staff and volunteers are up to date in the knowledge necessary to complete their duties.

10. Recruit, screen and support the staff and volunteer workforce for the program. As such, the Subgrantee shall:
    a. Provide formal training opportunities for SHIBA coordinators and volunteers utilizing state and federal training materials, at times including the preparation of copies of materials.
    b. At minimum, annually host one two day New Volunteer Training with the appropriate amenities, e.g. water, coffee, tea and or juice and light snack.
    c. Ensure completion of the volunteer application form, federal fingerprint-based criminal background check and confidentiality/non-conflict of interest forms for all volunteers.
    d. Ensure that all volunteers who provide one-to-one counseling and education seminars have satisfactorily completed extended training and volunteers of all other job descriptions have satisfactorily completed basic training.
    e. Ensure that all volunteers have satisfactorily completed their certification and notify the state SHIBA office upon the completion of all training (e.g. on-line training, 2-day New Volunteer Training and 10 hours of job-shadowed counseling sessions).
    f. Implement quality assurance protocols within the program.
    g. Provide up-to-date resources, information, and training libraries (either in paper or electronic) to local volunteers.
    h. Facilitate bi-monthly volunteer support meetings.
    i. Create and support full local volunteer access to Internet-based information, training materials, counseling, and enrollment tools as necessary.
    j. Train volunteers on the use of Internet-based counseling, SHIBA program tools, and Internet-based enrollment tools.
    k. Solicit direct feedback from counselors to determine if the training and support materials they receive are helpful in counseling activities.
    l. Ensure that any notices from state or federal resources are delivered and explained to counselors in a timely manner.
    m. Be responsible for the actions of the volunteers.

11. Ensure that SHIBA services are publicized to Medicare beneficiaries throughout the program area. Maintain contact with the community, including distributing literature and speaking at public gatherings to promote SHIBA.

12. Sponsor at least one recognition event annually for SHIBA volunteers at a minimal cost.

13. Increase SHIBA participation in CMS education activities. The Subgrantee shall:
    a. Ensure SHIBA Coordinator and Volunteers access to training materials through registration on www.shiptalk.org.

b. Ensure that the SHIBA Coordinator sends local event information and outreach activities to the state SHIBA office for posting to the state SHIBA website calendar of events.
c. Ensure contact information for the Subgrantee on www.shiptalk.org is accurate and current.

14. Respond to constituent requests for information or assistance in a timely fashion (the standard is within two (2) business days).

15. The Subgrantee shall make available to SHIBA copies of all publications, intake forms, training materials, systems, items developed and samples of any forms used by the Subgrantee to provide these services. The Subgrantee agrees to grant the Federal Government, the Centers for Medicare and Medicaid Services (CMS), royalty-free, non-exclusive and irrevocable rights to reproduce, publish or otherwise use, and authorize others to use the items.

16. All SHIBA materials published by the Subgrantee shall include the acknowledgement that "This publication has been created or produced by Subgrantee (official name) with financial assistance, in whole or in part, through a grant from the Centers for Medicare and Medicaid Services, the Federal Medicare agency." The Subgrantee shall use the SHIP logo and tagline on grant related publications. The Subgrantee shall also state that "Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the HHS and SHIBA."

17. Ensure program/agency representation at SHIBA Coordinator meetings/trainings/conference calls.

18. Develop a local program work plan collaboratively with State SHIBA office staff to at minimum meet the performance benchmarks for the eight (8) National SHIP Performance Measures provided by CMS. The performance measure period is July 1 through June 30 of each year. Individual Subgrantee and statewide performance reports will be provided annually by the SHIBA Program Manager.

19. The Subgrantee shall establish the capability to send and receive e-mail and to access and download Internet published information in the provision of SHIBA services.

20. State SHIBA will monitor and assess programmatic records, reports and activities under this Agreement and a work plan will be developed to determine the effectiveness and efficiency of service delivery. State SHIBA and CMS or the appropriate designee shall have ready access to all reports and records relating to this Agreement, subject to the maintenance of client confidentiality required by all governing entities.

21. The Subgrantee is required to notify the SHIBA Program Manager of any changes in key personnel, contact information, or other significant administrative changes immediately upon learning of the change. This includes, but is not limited to,

notification of inactive or terminated volunteers and changes to permissions for Unique IDs issued.

22. Enter the following into Shiptalk National Performance Report (NPR), located on the web at https://shipnpr.shiptalk.org/Default.aspx , on a monthly basis and no later than the following quarterly due dates: July 31 (Apr./May/June) October 31 (July/Aug./Sept.) January 31 (Oct./Nov./Dec.) April 30 (Jan. /Feb. /Mar.).

    a. Data for all Client Contacts
    b. Data for all Public and Media Activities

23. Provide Resource Report data to the state SHIBA office by April 30 of each grant year for incorporation into the state's Annual Resource Report required by CMS. A Microsoft Excel template will be provided to Subgrantee by the state SHIBA office prior to reporting due date.

24. Provide the SHIP Director or Designee information regarding upcoming events on a monthly basis and no later than the 10th day of the month prior to the event.

25. Provide information for input into the SHIP Grant Mid-term Report by September 15 of each year. Report form will be provided by the SHIP Director. The Mid-term progress report covers the period of April 1 through August 31 of each grant year.

26. The Subgrantee will assume responsibility for the accuracy and completeness of the information contained in all documents and reports.

27. All records pertaining to the SHIP grant including NPR data shall be retained as described in 45 Code of Federal Regulation (CFR) Section 92.42. Copies or other facsimiles of program records, such as electronic media, are acceptable substitutions for original documents.

28. Financial reports shall be required in accordance with State and Federal grant policies and procedures.

IV. CONSIDERATION AND USE OF FUNDS:

a. SHIBA agrees to pay the Subgrantee **$3,000** on a semi-annual reimbursement basis for providing local SHIBA counseling services for **Lincoln County** and for the performing the duties and responsibilities outlined under this Agreement. **$6,000** is the not to exceed amount under this agreement. This payment shall be the sole monetary obligation of SHIBA, and the obligation to pay is limited by the provisions of Section VII. Termination. Payment of all federal, state, county or city taxes/assessments and any other charges imposed by law upon employers shall be the sole responsibility of the Subgrantee.

b. Subgrantee will not submit invoices for, and SHIBA will not pay any amount in excess of the maximum compensation amount set forth above. SHIBA will make

interim payments to the Subgrantee following the review and approval of invoices submitted by Subgrantee.

c. The Subgrantee agrees to submit final invoice for work completed under this Agreement not later than 30 days after expiration date of this Agreement.

d. All invoices shall be submitted to:

SHIBA
Attn: Lisa Emerson
350 Winter ST. NE, Rm. 330
Salem, Oregon 97301

e. All invoices shall itemize and explain all expenses for which reimbursement is claimed.

f. Payment of all invoices is subject to the approval of SHIBA.
SHIBA certifies that at the time the Agreement is written that sufficient funds are available and authorized for expenditure to finance costs of this Agreement within the SHIBA's current appropriation or limitation.

g. SHIBA must use the funds as described in the State Health Insurance Assistance Program annual grant funding opportunity announcement #HHS-2012-CMS-CONT-SHIP. If SHIBA uses these funds for any purpose other than those awarded, then SHIBA may be required by to return the funds to the United States Treasury. Therefore, Subgrantee shall not use any amount of funds SHIBA pays to Subgrantee under this Agreement in a manner that could trigger the SHIBA's obligation to return the funds.

V. TRAVEL AND OTHER EXPENSES

SHIBA shall allow for travel expense reimbursement under this agreement up to $2,000.

VI. AMENDMENTS

The terms of this Agreement shall not be waived, altered, modified, supplemented or amended except by written instrument signed by both parties. This Agreement may be extended upon written amendment. The Agreement not to exceed amount may be increased to reflect any authorized extension period.

VII. TERMINATION

This Agreement may be terminated by mutual consent by both parties or by either party upon thirty (30) days' notice, in writing.

VIII. NON-PERFORMANCE

Neither party shall be held responsible for delay or failure to perform when such delay or failure is due to fire, flood, epidemic, strikes, acts of God or the public enemy, unusually severe weather, legal acts of public authorities, or delays or defaults caused by public carriers, which cannot be reasonably foreseen or provided against. Either party may terminate the Agreement, effective with the giving of written notice,

after determining such delays or failure will reasonably prevent successful performance in accordance with the terms of this Agreement.

IX. ALTERNATIVE DISPUTE RESOLUTION

The parties should attempt in good faith to resolve any dispute arising out of this Agreement. This may be done at any management level, including at a level higher than persons directly responsible for administration of the Agreement. In addition, the parties may agree to utilize a jointly selected mediator or arbitrator (for non-binding arbitration) to resolve the dispute short of litigation.

X. INSURANCE

If any third party makes any claim or brings any action, suit or proceeding alleging a tort as now or hereafter defined in ORS 30.260 ("Third Party Claim") against a party (the "Notified Party") with respect to which the other party ("Other Party") may have liability, the Notified Party must promptly notify the Other Party in writing of the Third Party Claim and deliver to the Other Party a copy of the claim, process, and all legal pleadings with respect to the Third Party Claim. Either party is entitled to participate in the defense of a Third Party Claim, and to defend a Third Party Claim with counsel of its own choosing. Receipt by the Other Party of the notice and copies required in this paragraph and meaningful opportunity for the Other Party to participate in the investigation, defense and settlement of the Third Party Claim with counsel of its own choosing are conditions precedent to the Other Party's liability with respect to the Third Party Claim.

With respect to a Third Party Claim for which the State is jointly liable with the Subgrantee (or would be if joined in the Third Party Claim), the State shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred and paid or payable by the Subgrantee in such proportion as is appropriate to reflect the relative fault of the State on the one hand and of the Subgrantee on the other hand in connection with the events which resulted in such expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of the State on the one hand and of the Subgrantee on the other hand shall be determined by reference to, among other things, the parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. The State's contribution amount in any instance is capped to the same extent it would have been capped under Oregon law if the State had sole liability in the proceeding.

With respect to a Third Party Claim for which the Subgrantee is jointly liable with the State (or would be if joined in the Third Party Claim), the Subgrantee shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred and paid or payable by the State in such proportion as is appropriate to reflect the relative fault of the Subgrantee on the

one hand and of the State on the other hand in connection with the events which resulted in such expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of the Subgrantee on the one hand and of the State on the other hand shall be determined by reference to, among other things, the parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. The Subgrantee's contribution amount in any instance is capped to the same extent it would have been capped under Oregon law if it had sole liability in the proceeding.

XI. Subgrantees

Subgrantee shall take all reasonable steps to cause its subgrantee(s) that are not units of local government as defined in ORS 190.003, if any, to indemnify, defend, save and hold harmless the State of Oregon and its officers, employees and agents ("Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including attorneys' fees) arising from a tort (as now or hereafter defined in ORS 30.260) caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Subgrantee or any of the subgrantees, officers, agents, employees ("Claims"). It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by the Subgrantee from and against any and all Claims.

XII. Subgrantee Insurance Requirements

Subgrantee shall require its first tier contractor(s) that are not units of local government as defined in ORS 190.003, if any, to: i) obtain insurance specified under TYPES AND AMOUNTS and meeting the requirements under ADDITIONAL INSURED, "TAIL" COVERAGE, NOTICE OF CANCELLATION OR CHANGE, and CERTIFICATES OF INSURANCE before the contractors perform under agreement between Subgrantee and (the "contractor"), and ii) maintain the insurance in full force throughout the duration of the agreement. The insurance must be provided by insurance companies or entities that are authorized to transact the business of insurance and issue coverage in the State of Oregon and that are acceptable to Agency. Subgrantee shall not authorize contractors to begin work under the agreement until the insurance is in full force. Thereafter, Subgrantee shall monitor continued compliance with the insurance requirements on an annual or more frequent basis. Subgrantee shall incorporate appropriate provisions in the agreements permitting it to enforce contractor compliance with the insurance requirements and shall take all reasonable steps to enforce such compliance. Examples of "reasonable steps" include issuing stop work orders (or the equivalent) until the insurance is in full force or terminating the agreements as permitted by the agreements, or pursuing legal action to enforce the insurance requirements. In no event shall Subgrantee permit a contractor to work under a agreement when the Subgrantee is aware that the contractor is not in compliance with the insurance requirements. As used in this

section, a "first tier" contractor is a contractor with which the Subgrantee directly enters into an agreement.

XIII. NONDISCRIMINATION

The parties agree to comply with all applicable requirements of Federal and State civil rights and rehabilitation statutes, rules and regulations in the performance of this Agreement.

XIV. COMPLIANCE WITH APPLICABLE LAWS AND STANDARDS

Subgrantee shall comply with all federal, state and local laws, regulations, and ordinances applicable to this Agreement or to Subgrantee's obligations under this Agreement, as those laws, regulations and ordinances may be adopted or amended from time to time. Unless exempt, Subgrantee shall comply and, as indicated, cause all subcontractors to comply with the following federal requirements to the extent that they are applicable to this Agreement, to Subgrantee, or to the Services or deliverables, or to any combination of the foregoing. For purposes of this Agreement, all references to federal and state laws are references to federal and state laws as they may be amended from time to time.

a. Audits

Subgrantee shall comply and, if applicable, cause subcontractors or subgrantees to comply with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations" as implemented by 45 CFR 92.26. The SHIBA reserves the right to audit, at the SHIBA's expense, all records pertinent to this Agreement.

b. Miscellaneous Federal Provisions

Subgrantee shall comply and cause all subcontractors or subgrantees to comply with all federal laws, regulations, and executive orders applicable to the Agreement. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the Agreement and required by law to be so incorporated.

1. Age Discrimination Act of 1975,
2. Civil Rights Act of 1964 (Title VI),
3. Controlled Substances; Education Amendment of 1972 (Title IX),
4. Public Health Security and Bioterrorism Preparedness and Response Act, Rehabilitation Act of 1973 (Section 504),
5. USA PATRIOT Act,
6. Americans with Disabilities Act of 1990,
7. Clean Air, Clean Water, EPA Regulations,
8. Energy Efficiency,
9. Truth in Lobbying,
10. Resource Conservation and Recovery,

11. Debarment and Suspension.
12. Pro-Children Act.
13. 15 CRF Part 14 , and
14. Office of Management and Budget (OMB) Circulars A-110 and A-122
15. Trafficking in Persons

XV. PARTNERSHIP

Neither party is, by virtue of this Agreement, a partner nor joint venture in connection with activities carried out under this Agreement, and shall have no obligation with respect to the other party's debts or any other liability or obligation of the other party of whatever kind of nature.

XVI. NO WAIVER OF CLAIMS

The failure by either party to enforce any provision of this Agreement shall not constitute a waiver by that party of that provision or of any other provision or provisions of this Agreement.

XVII. CONFIDENTIAL INFORMATION

Subgrantee shall comply with ORS 646A and require subcontractors or subgrantees to comply with the information security requirements imposed under this section. "Information Asset" means all confidential information in any form (e.g., written, verbal, oral or electronic) which SHIBA determines requires security measures, including confidential information created by SHIBA, gathered for SHIBA, or stored by SHIBA for external parties.
All requirements imposed on Subgrantee under this section 5 shall also apply to its officers, employees, agents and subcontractors that have access to any SHIBA information computer system or other SHIBA Information Asset, and Subgrantee shall include these requirements in any subcontract that may provide such access by a subcontractor, its officers, employees or agents to any SHIBA computer system or other SHIBA Information Asset. Subgrantee shall:
Cooperate with SHIBA in identifying Information Assets that will be utilized in the performance of Services or for the delivery of Goods and applicable security measures that will be undertaken to protect the Information Assets, and provide updated information to SHIBA within fourteen (14) calendar days of the date such information changes for any reason.
Implement security measures that reasonably and appropriately provide administrative, physical and technical safeguards that protect the confidentiality, integrity and availability of the Information Assets that it creates, receives, maintains or transmits on behalf of SHIBA. Subgrantee security measures must be documented in writing and be available for review by SHIBA upon request. SHIBA's review of the reasonableness of security measures, as well as Subgrantee's compliance with SHIBA's assigned access control or security requirements, will take into account

Subgrantee's physical, administrative, and technical capabilities related to security measures and the potential risk of unauthorized use or disclosure of Information Assets by Subgrantee, its officers, employees, agents or subcontractors.
Prevent any unauthorized access to or disclosure of SHIBA's information systems and information assets.
Take necessary actions to comply with SHIBA's determinations of the level of access that may be granted, as well as changes in level of access, or suspension or termination of access as determined by SHIBA.
Keep any SHIBA-assigned access control requirements such as identification of authorized user(s) and access-control information in a secure location until access is terminated; monitor and securely maintain access by Subgrantee and its agents or subcontractors in accordance with security requirements or access controls assigned by SHIBA; and make available to SHIBA, upon request, all information about Subgrantee's use or application of SHIBA access-controlled computer systems or Information Assets.
Report to SHIBA any privacy or security incidents by Contractor, its officers, employees, agents or subcontractors that compromise, damage, or cause a loss of protection to SHIBA Information Assets. Subgrantee shall report in the following manner.
Report to SHIBA in writing within five (5) business days of the date on which Subgrantee becomes aware of such incident; and
Provide SHIBA the results of the incident assessment findings and resolution strategies.
Subgrantee shall comply with SHIBA requests for corrective action concerning a privacy or security incident, and with laws requiring mitigation of harm caused by the unauthorized use or disclosure of confidential information, if any.
If SHIBA determines that Subgrantee's security measures or actions required under section 5.A are inadequate to address the security requirements of SHIBA, SHIBA will notify Subgrantee. SHIBA and Subgrantee may meet to discuss appropriate security measures or action. If security measures or corrective actions acceptable to SHIBA cannot be agreed upon, SHIBA may take such actions as it determines appropriate under the circumstances. Actions may include but are not limited to restricting access to computer systems or Information Assets, or SHIBA amending or terminating the Contract.
SHIBA may request additional information from Subgrantee related to security measures, and may change, suspend or terminate access to or use of a SHIBA computer system or Information Assets by Subgrantee, its officers, employees, agents or subcontractors.
Wrongful use of SHIBA computer systems, wrongful use or disclosure of Information Assets by Subgrantee, officers, its employees, agents or its subcontractors may cause the immediate suspension or revocation of any access granted through this Agreement, in the sole discretion of SHIBA. SHIBA may also pursue any other legal remedies provided under the law.

XVIII. ENTIRE AGREEMENT

SHIBA SUBGRANTEE AGREEMENT Agreement # SHIBA1213-11

This Agreement constitutes the entire agreement between the parties concerning the subject matter of this Agreement and superseded any and all prior or contemporaneous negotiations or agreements among the parties, if any, whether written or oral, concerning the subject matter of this Agreement which is not fully expressed herein. This Agreement may not be modified or amended except in writing and signed by all parties.

XIX. SIGNATURES

The undersigned hereby accepts the SHIP subgrant and agrees to comply with the foregoing Agreement and with all applicable state and federal laws, regulations and policies relating to the grant.

Department of Consumer and Business Services, Insurance Division, SHIBA

Authorized Representative/designee Date 6/15/12

Oregon Cascades West Council of Governments

Authorized Representative/designee Date 5/18/12